A CONTINUUM OF MUSIC THERAPY PRACTICE AND PEDAGOGY

CRITICAL REVIEW

Output document

A submission presented in partial fulfilment of the requirements of the University of South Wales/Prifysgol De Cymru for the degree of Doctorof Philosophy

June 2021

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Introduction

This document contains pdfs and weblinks for all outputs forming part of the Critical Review.

Project 1.

Table 1 lists the outputs in this project. Output 1.9 is the book '*Music therapy and autism across the lifespan: A spectrum of approaches' (*Dunn et al, 2019). Output 1.10 is the final chapter of this book. Outputs 1.1.7 and 1.11 are online resources, They can be accessed by clicking the link next to each output.

Project 1 outputs
1.1 Bunt,L. Coombes, E. Hung Hsu, M., Lindeck, J., Loth, H., Proctor, S., Twomey, T., Vaz, A. & Watson, T.(2014) How We Learn, How We Teach: Do Music Therapy Training Courses Provide the Skills Required for the 21st Century Working Environment? In G. Tsiris, C. Warner & G. Watts (Eds.) *Counterpoints: Music Therapy Practice in the 21st Century,* London: BAMT, p.27.
1.2 Coombes, E. Holden, S & Evans, K. (2016) '*A problem shared – Problem Based Learning in practice: enhancing student and practitioner clinical reasoning'* [Poster] BAMT Conference: Revisiting our voice – Resourcing music therapy for contemporary needs, Glasgow, April 8-10.
1.3 Coombes, E. (2017b) *'The importance of listening, just listening'* [Poster] 4th SAME International Conference Exploring the Spiritual in music: interdisciplinary dialogues in music, wellbeing and education, London December 8-10.
1.4 Holden, S. Coombes, E & Evans K. (2018) 'Do Problem-Based Learning approaches provide effective educational interventions for music therapy training courses? Experiences from an action research project at the University of South Wales', *Approaches: An Interdisciplinary Journal of Music Therapy,* First View (Advance online publication), pp. 1-16 http://approaches.gr/wp-content/uploads/2020/04/5-Approaches-12-1-2020-a20180406-holden.pdf
1.5 Coombes, E. (2018) 'We all came from somewhere', *Voices: A World Forum for Music Therapy,* Vol 18(1). Available at:

https://voices.no/index.php/voices/article/view/2539
1.6 Coombes, E., Bryant, F., Morgans, P., Trethewey, R & Pickard, B. (2018) '*Research into practice – exploring how personal interests can shape practitioner identity'* [Poster] BAMT Conference: Music, Diversity, Wholeness, London: February 14-16.
1.7 Coombes, E. (2018) 'Music Therapy Conversations – Liz Coombes' *podcasts.* Available at: https://player.fm/series/music-therapy-conversations/ep-19-liz-coombes (Accessed 4 May 2020)
1.8 Coombes, E & Pickard, B. (2018) 'Y*our passion will lead you to your purpose'* [Poster] The Nordic Congress for Music Therapy, Stockholm, August 8-12.
1.9 Dunn, H., Coombes, E., Maclean, E., Mottram, H., & Nugent, J. (2019) *Music therapy and autism across the lifespan: A spectrum of approaches.* London: Jessica Kingsley Publishers.
1.10 Coombes, E., & Maclean E. Co-Author of Chapter in the above book with Emma Maclean (2019) 'Postlude: Music therapy and autism across the lifespan' in Dunn, H., et al (2019) *Music therapy and autism across the lifespan: A spectrum of approaches.* London: Jessica Kingsley Publishers.
1.11 Coombes, E. (2019) *Anxiety: a playlist to calm the mind from a music therapist.* Available at: https://theconversation.com/anxiety-a-playlist-to-calm-the-mind-from-a-music-therapist-121655 (Accessed 4 May 2020)
1.12 Coombes, E. (2020) 'Betwixt and between: considering liminality and rites de passage in the context of music therapy in a specialist further education college' The Arts in Psychotherapy, Vol 67. Available at: https://www.sciencedirect.com/science/article/pii/S0197455619301789 (Accessed 20 June 2020)
1.13. Coombes, E. Pickard B. (2020) 'Riding in tandem: journeying the research-teaching nexus in partnership', [Presentation] *Online Conference for Music Therapy* 1 February.

Project 2

All outputs for this project are also contained in pdf format.

Project 2 ouputs
2.1 Coombes, E. (2011) 'Project Bethlehem – training educators and health workers in the therapeutic use of music in the West Bank', *Voices: A World Forum for Music Therapy,* Vol 11(1). Available at: https://voices.no/index.php/voices/article/view/1943 (Accessed 2 June 2020)
2.2 Coombes, E. (2011) 'Project Bethlehem training booklet', Vol 11 (1) https://voices.no/index.php/voices/article/view/1943 (Accessed 2 June 2020)
2.3. Coombes, E. & Tombs-Katz, M. (2015) 'Interactive therapeutic music skill sharing in the West Bank – an evaluation report of Project Beit Sahour, *Approaches: An Interdisciplinary Journal of Music Therapy,* First View (Advance online publication pp.1-12. https://approaches.gr/coombes-a20150327/ (Accessed 2 June 2020)
2.4 Coombes, E. (2017) 'How can interactive therapeutic music help populations living in a situation f high stress of who may have experienced trauma?' [Spotlight Session] World Congress for Music Therapy, Tsukuba, Japan, July 5.
2.5 Coombes, E. (2019) *Intercultural dimensions of music therapy practice and training: what resonates with whom?,* [Paper] 11th European Conference for Music Therapy, Aalborg, June 26-30.
2.6 Saada, B. & Coombes, E. (2019) 'Music Therapy in the Occupied Palestinian Territories: Special Edition on music therapy in Mediterranean countries with a focus on dementia and palliative care,' *Approaches: An Interdisciplinary Journal of Music Therapy,* First view pp.3-8. http://approaches.gr/wp-content/uploads/2020/12/11-Approaches-12-2-2020-r20200602-saada.pdf (Accessed 2 June 2020)

Project 3

Output 3.1 can be accessed by the link the table. All the other outputs for this project are contained in pdf format.

Project 3
3.1 Coombes, E. (2019) *Music therapy improves the health of premature babies and boosts parental bonding.* Available at: https://theconversation.com/music-therapy-improves-the-health-of-premature-babies-and-boosts-parental-bonding-118281 (Accessed 4 May 2020)
3.2 Coombes, E. (2019) *'The singing unit',* [Pecha Kucha] USW Research Conference. Treforest: July 5, 2019.
3.3 Coombes, E. (2019) 'The singing unit – Can a music therapy workshop in a local neonatal unit increase parents' ability to bond with their babies and reduce anxiety?', [Unpublished report].
3.4 Coombes, E. & Al-Muzaffar, I. (2020) 'The singing unit – Can a music therapy workshop in a local neonatal unit increase parents' ability to bond with their babies and reduce anxiety?', *Journal of Neonatal Nursing* (accepted in press).

Panel discussion 4

Training and education

How we learn, how we teach: do music therapy training courses provide the skills required for the 21st century working environment?

Chair:
Tessa Watson
University of Roehampton

Panel members:
Leslie Bunt[1], Liz Coombes[2], Ming Hung Hsu[3], Jackie Lindeck[4], Helen Loth[5], Simon Procter[6], Tim Twomey[7] & Anita Vaz[8]

[1] University of the West of England, [2] University of South Wales,
[3] Methodist Homes, [4] Coram, [5] Anglia Ruskin University, [6] Nordoff Robbins Music Therapy,
[7] The Children's Trust, [8] Freelance Music Therapist

ABSTRACT

This session will consider the development of music therapy training in the UK, and whether it is meeting the needs of both students and the changing working environment of the 21st century. Therapy services in general are increasingly moving from statutory providers to charitable and other third sector organisations. At the same time, the Arts for Health agenda is challenging therapists to deliver their services and skills in different and innovative ways. The Training and Education committee is keen to hear the views of all music therapists, trainers and employers on what needs to be changed, adapted and added to music therapy core training. In order to do this, the history and development of music therapy training to date will first be presented followed by brief presentations from two trainers who recently started or redesigned music therapy training course. Two recent graduates will then present their experience of beginning work, how prepared they found themselves, and what if any other subjects would have been useful on their training course. The presentations will conclude with two employers giving their views on the skills needed now by therapists in the workplace, and whether they find that graduates have been taught them. A full discussion with trainers and audience members will be encouraged to explore these issues in depth.

A Problem Shared…. Problem Based Learning in Practice

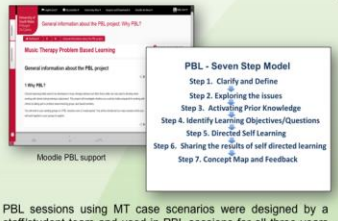
Enhancing Student and Practitioner Clinical Reasoning

Background

This Problem Based Learning (PBL) project was an educational intervention piloted across all years of the MA in Music Therapy at the University of South Wales.

The project, supported by a USW Learning Innovation Grant, explored whether the development of music therapy students' practical and clinical reasoning skills could be enhanced by using a PBL approach during training

Pre and post PBL surveys were completed by students with particular reference to clinical reasoning skills. The outcomes demonstrated that engaging with the PBL process had a positive effect on this area of their skillset. Moreover, students valued the experience and felt it had given them a realistic insight into clinical work.



Moodle PBL support

PBL sessions using MT case scenarios were designed by a staff/student team and used in PBL sessions for all three years of the Music Therapy MA.

The project used the 7-Step model of PBL and each PBL case covered a 2 week period: 2 PBL sessions and Self Directed Learning (SDL).


Year 2: Adult Mental Health: Case Scenario: Julia: Concept Map

Pre and post test surveys were designed to obtain students' feedback on:-

- confidence in their clinical reasoning skills (7 questions based on 5 HCPC standards)
- their anticipation of and the actual experience of the PBL process (3 questions)
- whether they would like more of the curriculum delivered using this approach

A focus group followed up on issues arising from the Y1 survey results. Sessions were observed by the course leader and another Y3 student

Survey questions covered students' confidence in their ability to carry out several areas of clinical reasoning:- assessment and diagnostics, conducting music therapy, formulating treatment plans, undertaking investigations, observing and recording users' responses, using research skills to determine actions and using problem solving skills to determine actions.

Methodology

Year 1: Autism: Case scenario: Ben

Ben is a 6 year-old child who attends a specialist ASD school. He has one younger brother. Parents report that Ben met all of his developmental milestones until the age of 18 months when he began to withdraw and to lose some communicative skills. At present, he is non-verbal and exhibits many stereotypic behaviours including hand-flapping and spitting. He can become upset very easily when routines are challenged leading to an escalation of difficult behaviours including injuring others and himself through biting and pinching.

When Ben is calm he is easy to engage and appears to enjoy relaxing to music. Ben really enjoyed some recent visits by community musicians when they came to his school. His teacher feels that a music therapy assessment may help staff understand Ben better. She also wonders if music therapy could support Ben in his development of more interactive skills as well as a better way of regulating his emotions.

Questions about PBL explored:- students' previous experience, anticipation of the effects on their learning (pre PBL), effects on their learning experience (post PBL) and their opinions on more PBL to deliver the MT curriculum

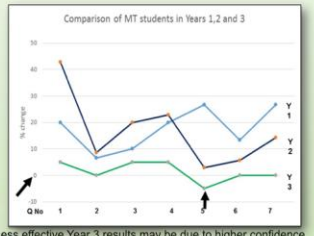
Student feedback on the PBL experience

"creative…engaging…more interactive…
better way of learning…like working in real life…
enjoyed it…liked being the scribe
and more active……gathering it together
and bringing it to the group where it was discussed and
digested…it was a good
thing to chew findings over together…
the wisdom of the crowd leads to useful
and interesting territory"

Results

Effects on MT students' clinical confidence?

- Years 1 and 2: students' confidence in several aspects of their clinical reasoning skills were positively affected by taking part in the PBL process
  - Effects were more pronounced in year 2
- Year 3: taking part in the PBL process resulted in very little change in students' confidence in their clinical reasoning skills
- Positive or neutral effects (1 negative effect in Y3 Q5)
- Differences and similarities across the years



Less effective Year 3 results may be due to higher confidence levels in areas of clinical reasoning:
possibly due to their experience of 2 years' placement

Response to PBL? ALL students in ALL years…

- valued the experience
- would like more of the MT curriculum delivered this way

Effects on other areas of student learning were commented on e.g. PBL…

- increased their motivation to carry out SDL
- gave them a model of working through a topic area for other educational tasks such as essays

Next steps?

- expand use within MT and beyond
- use case scenarios with mixed modality groups
- develop required academic expertise
- further research to inform decisions

University of South Wales Prifysgol De Cymru

Liz Coombes: Course Leader MA Music Therapy: University of South Wales

Sally Holden: Music Therapist: University of South Wales Alumni

The Importance of Listening - Just Listening....

Background

BMGIM

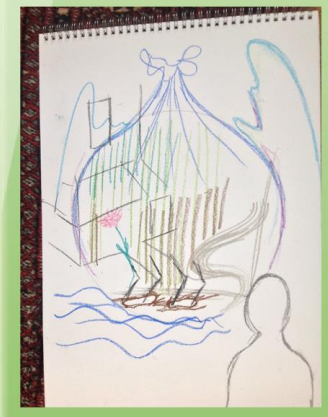
The Bonny Method of Guided Imagery and Music (BMGIM) was developed by Helen Bonny in the latter part of the C20th.She described it as 'the purposeful use of prepared classical music by a guide or facilitator to evoke sensory and emotional responses to the listener. These responses, in the form of imagery, symbols, feelings, past and present life review, sensations, unfolding metaphors and transformative experiences, become the heart of the session" (Bonny 2001).

I myself am currently an advanced student on the GIM training. I am also a practising music therapist and the Course Leader of the MA Music Therapy at the University of South Wales, UK (http://www.southwales.ac.uk/courses/ma-music-therapy/).

While teaching, I have become aware of a growing interest in transpersonal/spiritual experience in many music therapy students, as well as evidence of the same in qualified practising music therapists (Tsiris 2016).

I began to wonder whether aspects of GIM philosophy and theory could be beneficial to trainee music therapists. This has led me to include music and imagery experiential elements in different teaching seminars.

Experiential group work with MA music therapy students and art psychotherapy students have been offered.Supervision groups and music therapy skills teaching have all been enriched by the addition of a variety of different ways of listening and responding to music, be they excerpts from Bonny programmes, or pieces selected by myself to work on certain aspects of practice.



Personal

A resource for strengthening personal identity

Trondalen (2014) has explored resource-orientated Bonny Method of Guided Imagery and Music as a creative health resource for professional musicians and music students. Hyun Bae (2010) has described her own personal journey through reflections on her GIM training.

Fellow GIM students have reflected:

"*I can connect with deeper understandings of important issues in my current life - conscious and unconscious. I feel creative about possible solutions."*

And:

"The training teaches me the importance of listening - just listening…."

Reflection on journeys and images, such as those below, can enable the music therapist to have a fresh perspective on their own relationship with music and spirituality, re-evaluating the music they create and listen to in their personal lives.

Clinical

Authentic self-presence evoked by the GIM process - its role in a more authentic therapeutic identity

I suggest that my study of GIM as enabled a mature and deep reflection on my relationship with music, and has impacted on my clinical work as a result of this.

Working using active music therapy with a group of service users at a hospice, I was able to attend to the music created by participants and observe it's qualities using similar processes to the guiding element of GIM. Post-improvisation discussion enabled participants to begin to think about their relationship with music, and how they could potentially use music listening at home to evoke and reflect their moods.

It was as though the group began to see the potential of music listening to "stretch the imagination, freeing and expanding the listener to transcend their current mode of presence in the world" (Beck 1997).

Students undertaking clinical practice in the hospice environment have begun to consider how best to use music listening in this context.

Pedagogical

"Impact on teaching and students self-supervision

Elements of GIM/MI practice are being incorporated into the course delivery of the MA Music Therapy . I have found these techniques enable me to experience the students differently and shed light on their needs, abilities, and learning styles. Connecting with them and acknowledging the importance of spirituality seems important.

Year 1 MA Music Therapy - An induction week experiential with the focus of a tree was offered. Students listened to the Adagio from Beethoven's Emperor Piano Concerto, and then created an image. There was a chance to discuss the process afterwards.

"I immediately felt so safe, which was good as I am embarking on a journey that will change me forever."

Year 2 MA Music Therapy - a group supervision session was framed with short music listening experiences to facilitate thinking around the working alliance. Students were encourage to create an image of themselves and their client. Solveig's Song by Grieg, and Wilma's Theme by Larsson were used to contain the thinking.

Year 3 MA Music Therapy - On the final day of training a group session used Richard Strauss' "Entsagung" from the 'Transitions' Bonny programme to facilitate their journey into the professional world of music therapy… Movement, darkness and light were used, with curtains drawn and torch beams piercing the darkness.

A student reflected:

" I felt uplifted and excited to finally be emerging into the world of music therapy with all that brings"

References:

Beck, D.M. (1997). Listening with Open Ears. Journal of the Association for Music and Imagery, 5, 25-36.

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Hyun Bae, M. (2010) Am I a Shaman? Transformation of a Korean GIM Fellow's and a Traditional Healer's Consciousness Through Music. Journal of the Association for Music and Imagery, 12, 61-73

Trondalen, G. (2014) Resource-oriented Bonny Method of Guided Imagery and Music (R-oGIM) as a creative health resource for musicians. Nordic Journal of Music Therapy , 25, 1, 5-31.http://dx.doi.org/10.1080/08098131.2014.987804

Tsiris, G. (2016) Music Therapy and Spirituality An international survey of music therapists perceptions.*Nordic Journal of Music Therapy*:, 25, 4 *1-27*

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ARTICLE

Do Problem-Based Learning approaches provide effective educational interventions for music therapy training courses? Experiences from an action research project at the University of South Wales

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ABSTRACT

A Problem-Based Learning (PBL) approach was piloted across the Master's in Music Therapy programme at the University of South Wales. The main aim of the project was to explore whether the development of music therapy students' practical and clinical reasoning skills could be enhanced by using a PBL approach during training. Case scenarios integrating many aspects of required learning covering key curriculum areas were developed and used in PBL sessions with each year group. The sessions were facilitated by a trained PBL facilitator and observed by the course leader. Students completed a pre- and post-PBL survey, giving information about their confidence in several areas of clinical reasoning. Feedback was also gathered on their views on the PBL approach and effects on their learning experience. Results show that engaging with the PBL process had a positive effect on students' clinical reasoning confidence, and that students valued the experience.

KEYWORDS

Problem-Based Learning,
clinical reasoning skills,
music therapy training,
research

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AUTHOR BIOGRAPHIES

Sally Holden, MA, FHEA, BSc. Sally is a registered music therapist and was one of the first graduates from the MA Music Therapy course at the University of South Wales. With a background in medical education, eLearning and PBL, she worked with academic staff at the University of South Wales to deliver this project, which formed the basis of her final year's MA music therapy dissertation. Sally works in several settings, including dementia care and with children living with the effects of trauma. [salholden@gmail.com] **Elizabeth Coombes**, MA, FHEA, BMus. Elizabeth is a registered music therapist (HCPC), university lecturer and musician. She is also the course leader of the MA Music Therapy course at the University of South Wales, Newport. Since qualifying in 2000, Elizabeth has specialised in working with children and young people with emotional and behavioural difficulties. She uses psychodynamic thinking to underpin her work, and also utilises her considerable experience in community music-making. She has worked on skill-sharing therapeutic music projects in the West Bank since 2009, and also in the UK. She has a particular interest in how sharing these skills with non-musicians such as teachers, social workers and carers can enrich their professional practice. She has a practice in palliative care and is an advanced GIM student. [elizabeth.coombes@southwales.ac.uk] **Dr Kathy Evans**, BEd, MA, MEd, PhD. Kathy was a teacher and manager for 15 years in both mainstream and specialist settings. Her doctorate was a cross-national study of the educational inclusion of pupils with social, emotional

and behavioural difficulties. Since 2010 she has been a senior lecturer at the University of South Wales, where she runs the MA Child and Adolescent Mental Health course. [Kathy.Evans@southwales.ac.uk]

INTRODUCTION

An essential and significant part of all music therapy training programmes in the UK is the clinical placement. Clinical placements as part of master's music therapy trainings in the UK are governed by the regulations of both clinical and university settings. These may vary according to each institution's requirements, but all courses ensure students attain the HCPC (Health and Care Professions Council) Standards of Proficiency (HCPC, 2013) by the end of their training. By the time students become practising music therapists, they will have usually worked in a variety of settings covering diverse areas of clinical practice.

It is widely recognised that clinical reasoning ability is a key skill for effective clinical work as music therapists. A roundtable presentation at the British Association for Music Therapy (BAMT) conference in 2014 (Bunt, Coombes, Hung Hsu, Lindeck, Loth, Procter, Twomey, Vaz and Watson) discussed this in relation to the development of clinical skills, current music therapy pedagogical practices and matters relating to employability. Music therapy students need to acquire a range of clinical skills as they develop their work with their clients and build their own therapeutic personas. Karen Goodman (2015) highlights the importance of these, including personal skills, therapy skills and music skills. The student music therapist then is charged with not only having sufficient musicianship to effectively meet the client in music but must also be able to select the most appropriate way of connecting with the client, using knowledge of the client's issues. There is therefore a complex interplay of skills needed that it is challenging to acquire and put into practice. The panel of the aforementioned roundtable, which was comprised of master's of music therapy programme trainers, researchers, employers and recent music therapy graduates, highlighted how clinical reasoning ability was an important skill required by employers/commissioners of music therapy. Ming Hung Hsu proffered the view that while employers realised that newly qualified music therapists could not have acquired in-depth knowledge about all the client groups they might be working with, it was important that there be an understanding of how such knowledge could be acquired.

Felicity Baker describes clinical reasoning as a practice that involves "integrating theory, evidence-based research (when it exists), and knowledge formed from prior experiences" (Baker, 2007, p. 28). When Music Therapy students begin their clinical practice during training, however, their prior experiences are limited. How then can they acquire and develop clinical reasoning skills during their years of training yet still develop robust practice that will enable them to gain employment and work effectively in clinical environments?

When reviewing the music therapy training programme at the University of Queensland, Baker (2007) observed that no component of the training specifically focused on developing clinical reasoning. This was also noted in a review of the MA Music Therapy course at the University of South Wales (USW) in 2014. There is an ongoing debate around the effectiveness of Practice-Based Learning (PBL) in affecting students' clinical reasoning in many professions, but these words from an occupational therapy student in a study of student perspectives of PBL, and in particular how it affects clinical reasoning, are particularly striking: "I think clinical reasoning is taking what you've learned in

PBL and being able to apply it to each individual person and a person as a whole, not just a diagnosis or a disability" (Hammel et al., 1998, p. 204). In an endeavour to foster and build clinical reasoning skills required not only while training but when in clinical practice, it was decided to pilot a PBL action-research project on the MA Music Therapy course at USW. The reasoning behind selecting this particular pedagogical method is set out below. The project was carried out over the academic year 2014-2015, and was funded by the CELT (Centre of Excellence in Learning and Teaching) at USW. It piloted the use of PBL with students in all years of the three-year part-time MA Music Therapy course and became the dissertation project of a Year 3 student who was also a trained PBL facilitator.

PROBLEM-BASED LEARNING (PBL)

The body of PBL pedagogy is vast and continues to grow. It covers many subject areas, approaches and educational settings. PBL is considered by David Boud to be "the most important development since the move of professional training into educational institutions". Yet he goes on to question why it continues to be "so attractive and yet so controversial" (Boud, 1997, p. 1).

Before covering some aspects of how PBL may be effective in developing music therapy students' clinical reasoning skills, it is useful to look at basic principles of PBL and models considered within that umbrella term. A definition of PBL by Howard Barrows, an early pioneer of this method in medical education, outlines its main characteristics as follows:

- learning is student-centred
- learning occurs in small groups
- teachers act as facilitators, guides or tutors
- problems form the organising focus and stimulus for learning
- problems are the vehicle for the development of clinical problem-solving skills (Barrows, 1996).

Other characteristics common to most forms of PBL and its hybrids include the acknowledgement of the experience and knowledge of learners, and students taking responsibility for their own learning under the guidance of a tutor. Key aims are the integration of theory with practice and the crossing of discipline boundaries. There is a focus on the process of knowledge acquisition rather than the products of the process. During the PBL process there is a change in staff roles from instructor to facilitator, and often a change from staff assessments of outcomes of learning to student self-/peer-assessment. There is also more emphasis on communication and interpersonal skills within the learning process (Savin-Baden, 2000).

PBL can be considered as a form of small-group learning which offers students the experience of working in a group of their peers with a trained facilitator. The stimulus for learning, the 'problem' in PBL, is presented in an appropriate format for the discipline and may use a variety of media. In medicine, for example, it might be "a written case, case vignette, standardised (also called simulated) patient, computer simulation, videotape" (Barrows, 1996, p, 5). Students are presented with the 'problem' in a similar way to how clients or patients present in reality with symptoms, complaints, issues etc., within a case or clinical vignette. Identification of what students in the group already know and what they then need to find out to solve the problem(s) are at the heart of the PBL process. From

this process, learning objectives are generated which are then researched by the group individually in self-directed learning (SDL), and brought back for discussion, debate and integration. Thus "students are expected to learn from the world's knowledge and accumulated expertise by virtue of their own study and research, just as real practitioners do" (Barrows, 1996, p. 6).

To summarise, PBL cases integrate aspects of required learning into a case scenario or clinical vignette, thereby providing a model for clinical reasoning in professional practice. Overall, then, "PBL can be seen as an example of a learning environment that fosters active, constructive, contextual, cooperative, and goal-directed learning" (Moust et al., 2005, p. 667). Once decisions were made on the subject areas, topics and levels of case complexity which were to be covered using a PBL approach, the next steps were to identify, modify and/or develop the required number of appropriate case scenarios or clinical vignettes. According to John Savery and Thomas Duffy, when generating problems for use in PBL "there are two guiding forces". These are: "to raise the concepts and principles relevant to the content domain" and, secondly, that "the problems should be real" (Savery & Duffy, 2001, p. 11). In many professions the problems can be based on real patients or amalgamations of patients/clients which raise the important points of content which faculty/academics decide are important for students to cover. Learners will tend to become more engaged with real problems, and their motivation to research the learning outcomes arising from it will be higher. Careful wording of case scenarios and the information within them will result in more effective learning being stimulated within the group and individuals.

A form of PBL, which is widely used and was first developed for use with medical students in Maastricht University, is the seven-step model (see Table 1). A new UK medical school adapted the same original seven-step model during its first 12 years of operation, adding an extra step of integration and transfer which aims to test the transferability of students' learning. This extra step involves similar cases to the PBL case scenario being introduced, as well as directed questions asked of the students before the final (now eighth) step. In the USW PBL project the basic seven-step model was used, but with modifications in the Year 2 and Year 3 student groups to include directed tasks which may also reinforce students' learning. As mentioned above with the medical students, adding this extra step was an attempt to influence the development of transferability of learning while the clinical placements were being undertaken. In Year 1, the pre-clinical phase, the original seven-step model was used, with emphasis placed on the concept-mapping. Concept-mapping as an activity is a way that students can visualise, organise and, thus, reinforce their learning during the SDL sharing stage of PBL. However, Geoff Norman points out that when students reinforce learning in the context of a single case or problem it may lead to later problems in transferring that learning to other scenarios (Norman, 2009). Thus, it is clear that there is a need to give students a variety of relevant problems and tasks which allow them to develop their transfer skills. Year 2 and Year 3 students were given relevant directed simulated tasks which reinforced their learning and practice in transferring learning to other clinical situations.

DESIGN, RESEARCH METHODOLOGY AND DATA COLLECTION

In summary, the USW PBL project's research aims were to explore whether a PBL approach was feasible in music therapy training at USW, and to find out whether it could help music therapy students

at different levels in their training prepare for clinical placements and future professional work. A key area for research was to find out whether music therapy students' confidence in their practical clinical reasoning skills used in the planning and delivery of music therapy interventions could be enhanced by using a PBL approach during training. The project also aimed to explore what perceptions the USW music therapy students had of PBL, its effects (if any) on their learning experience, and the factors which influenced those effects.

Steps	Activities
1	• Revealing the case scenario, which is read out by a group member • Clarification of terms and definition of what the case is about
2	• Brainstorming all possible aspects of the case • One of the group records (scribes) all discussion points on a whiteboard • Discussion of key issues arising from the case
3	• Identification of prior learning, i.e. what students already know
4	• Identification of areas which students need to find out more about • Formulation of learning objectives to be researched by each member of the group in their self-directed learning
5	Step 5 is carried out by students between PBL sessions one and two. • In between the first and second PBL session students are expected to research all the learning objectives formulated collaboratively by the group during their self-directed learning (SDL) • This allows the group to come to the second PBL session ready to feed back, share and exchange information
6	• Sharing results of SDL: students challenge, construct and fill gaps in their learning • Identify sources • Issues are debated, different opinions discussed/challenged/defended and consensus reached if/when there is confusion
7	This step has slight variations in each year related to an integrated clinical task or absence of it. • Concept map (Year 1) or task-based activity (Years 2 and 3) • Feedback

Table 1: The Maastricht PBL seven-step model with a brief explanation of each step

Action research (AR) was chosen as the research methodology since the project mapped against many of AR's main characteristics. It was practice-based, focused on improving learning, was collaborative, and could potentially contribute to social and cultural transformation. (McNiff, 2010). According to Paul McIntosh, action research "becomes a way of being that is full of potential, surprises and unpredictability, so absolute answers to questions become meaningless, because whatever is found becomes a new question" (McIntosh, 2010, p. 37). Since reflection is a fundamental part of music therapy practice, (Wheeler, 2002), the choice of an approach which makes use of the ability to think reflectively seems appropriate. Designing, running and evaluating this educational intervention and action-research project was a valuable exercise in reflection and reflexivity.

Research activities within the USW PBL project included design of the appropriate data collection methods which resulted in use of pre-/post-PBL student questionnaires and focus groups. Choices were made around an appropriate PBL model and subject area for each year group. The topic of each case scenario followed the subject that had been outlined in each year's timetable content. For example, in Year 1, at that point in the year, the students would have been studying autism and music therapy, so the PBL scenario was designed with this in mind. The same thinking process was used to design the scenarios for Years 2 and 3. A suite of pilot music therapy case scenarios in the agreed PBL format was then developed. Facilitation and delivery of the PBL sessions with students in each year group using the relevant PBL case scenarios was then followed by analysis of the results.

In this project there was a need to obtain answers for USW providing "findings, facts, clear expositions and straightforward policy recommendations" (Delamont, 2012, p. 4), as well as a need to explore freely, with students and staff, this new educational ground. As Tony Greenfield (2002) recommends, the research methods were carefully planned but the researchers remained open to "creative leaps" (Greenfield, 2002, p. 5) throughout, arising from unanticipated directions of travel and thought. A balance between approaches led to the research questions being answered using a combination of qualitative and quantitative methods. The combination of facts, figures and participants' experiences gathered using this mix of research methods led to a clearer picture of the overall effect of the use of a PBL approach in music therapy training in USW. There was also a need to carry out this research within the time constraints of the MA and therefore the study could be considered relatively "short-term" (Bell, 2010, p. 118). To ensure no extra time was being asked of students it was decided that all PBL sessions would be delivered during time slots already in all cohorts' timetables. Ideally a PBL session works well within a two- to three-hour time slot, but due to timetabling constraints this was not possible. All PBL sessions were therefore delivered during the weekly seminar slots of 1.5 hours. They were run over a two-week time period, giving students a week in between sessions one and two in which to carry out their self-directed study activities. Careful timing with the assessment calendar ensured that the sessions did not clash directly with deadlines in other areas of the course, thereby not putting extra pressure on students.

In summary, there were two PBL sessions of 1.5 hours per year group which were delivered in lecture slots over a two-week period. Each group was therefore in PBL sessions for a maximum of three hours. These sessions were delivered at various times over the academic year, with Years 2 and 3 being delivered in December 2014 and Year 1 being the last cohort to experience the PBL sessions during February and March 2015. These time factors, such as reduced session times and timetabling constraints, also produced limitations in terms of opportunities to test the reliability and validity of the various tools used.

The PBL project was designed and carried out by members of the staff/student MA Music Therapy course with input from the CELT department at USW. This included the music therapy course leader, the dissertation supervisor and a third-year student (all of whom are the authors of this paper). This in-house approach introduced a possible and anticipated inbuilt bias both from the researcher's position as well as from the academic staff. Strategies were put in place to counteract this bias where possible, and the researcher's position was clearly stated during the project and during the subsequent analysis, write-up and dissemination. The researcher became aware that her own positions as student/educator/researcher were constantly vying for dominance and influencing her thoughts. It

was also important throughout to recognise the "familiarity problem" as expressed by Sara Delamont (2012) when carrying out any type of educational research.

The participants in this project were music therapy master's students in three separate year cohorts. It was decided that using PBL in all years was something to be aimed for, rather than selecting only one or two of the three years. Using all years as participants would give the project more information in the form of students' experiences and feedback, and would also allow some comparisons across student cohorts at different stages in their learning. Limitations were imposed on this study by the numbers of students in each year. There was no opportunity to design research which compared the effects of PBL contrasted with control groups (with no PBL intervention) of similar sizes and compositions.

The cohorts from Years 1, 2 and 3 were recruited by a combination of initial contact from the course leader and PBL introductory sessions with the course leader and researcher. Students were given opportunities to ask questions and get answers about the project and their potential contribution to it. In terms of subjectivity, bias and ethical issues, some challenges within the Year 3 group were raised which are elaborated below.

Since the decision to replace some lectures with the PBL sessions in each year had already been taken by the course leader, it was important to explain to students the difference between the PBL project as an educational intervention and the research study. Since student participation in the PBL sessions was part of their course (obligatory as part of the expected 100% attendance policy) we wanted to avoid a sense of coercion on the part of any students when they were considering giving consent to their data and experience being used in the research. Information about the project and why it was being carried out was made available through an online site and given to students on paper-based materials within lectures and seminars. An online Music Therapy PBL Moodle site was set up for dissemination of information and to help support students' learning. Each PBL group was given a private online space within which they were able to explore any learning points they identified, and they were able to communicate with each other. The online presentation showed the key points about the PBL approach chosen and what generally happens within the PBL process and sessions.

As a result of the successful recruitment, three different PBL groups of students were set up; one in each year, with all students in each year agreeing to take part. There were eight students in Year 1, eight in Year 2 and five in Year 3. Since the music therapy year groups in each year are no larger than eight it was possible for each year's cohort to work as a single PBL group and there was no need to break them into smaller groups or randomly select participants etc. Depending on a range of factors, PBL groups work well at around six to nine people (Bessant et al., 2013), and so the numbers were almost ideal; although the Year 3 group was reduced to four in one session due to illness. These relatively small groups meant that the amount of data obtained was limited. However, there was a 100% participation rate from all students across all years. This also means that the findings are even more applicable across the programme and more relevant to the USW and its students since all three cohorts invested their interest, time, energy and commitment to this project.

Each PBL case equated to two facilitated PBL sessions and SDL between sessions. Pre- and post-test self-reporting surveys were designed to obtain students' feedback on the following aspects of the project:

- confidence in their clinical reasoning skills (seven questions based on five HCPC SOPs from section 14)
- their anticipation of and the actual experience of the PBL process (three questions)
- whether they would like more of the curriculum delivered using this approach

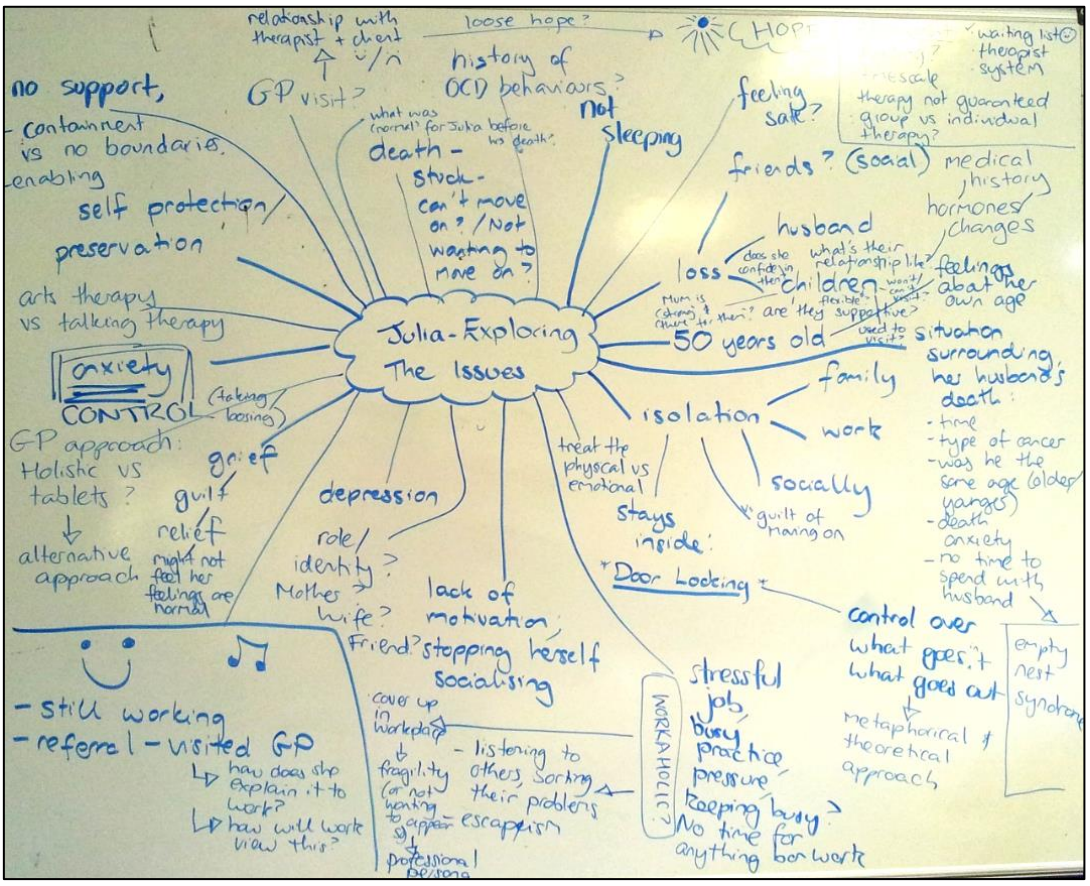
The self-reporting surveys (see Appendix) containing the seven final simplified questions arising from five HCPC SOPs were circulated for comments during the design stage to the course leader and dissertation supervisor. The questions were designed to be clear, unambiguous and yield reliable data. It was decided that the same questions would be used for all years, which would provide comparative data. A Likert scale was used for the clinical reasoning skills confidence questions, ranging from a score of 1 to 5 (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agree). Use of such a scale is recommended when data is needed on participants' opinions or attitudes (Tsiris, Pavlicevic & Farrant, 2014). A neutral choice (3) was included to prevent respondents having to choose options of which they were unsure. For the purposes of analysis, using this scale means that positive responses to the questions produce a higher score and the adjacent points on the scale can also be considered to be equidistant.

The self-reporting surveys were administered before and after the PBL cycles and can be seen in the Appendix. Questions covered two main areas: students' confidence in areas of clinical reasoning and attitudes to PBL. Questions were designed to explore students' confidence in their ability to carry out the following areas of clinical reasoning: assessment and diagnostics, conducting music therapy, formulating treatment plans, undertaking investigations, observing and recording users' responses, using research skills to determine actions, and using problem-solving skills to determine actions. Questions around the students' experience of PBL explored their previous experience, anticipation of the effects on their learning (pre-PBL), effects on their learning experience (post-PBL) and whether or not they would prefer more PBL to deliver the music therapy curriculum. A semi-structured focus group was held at the end of the PBL sessions with all of the Year 1 students, to follow up areas of ambiguity arising from the results of the Year 1 surveys.

All sessions were observed by the course leader and another Year 3 student to add another layer of feedback and enrich the evidence base. In each PBL cycle the seven-step model was followed and the various activities within each step can be seen in Table 1. In brief, during the initial PBL session, students were given the appropriate case scenario which was read aloud. (Year 1 and 2 PBL case scenarios can be seen in Box 2). A scribe was then identified from the group to graphically record the discussion points on a whiteboard (see Photograph 1). These discussion points were grouped and used to formulate learning objectives which all members of the group researched and brought back to the second PBL sessions for detailed discussions.

Since a mix of qualitative and quantitative data was collected within this research project there was a mixed approach to its analysis. The Likert scale quantitative data from the survey results was analysed by calculating the frequency of various responses and then converted to percentages. The data was also subjected to basic statistical tests and was presented in graphical and textual format as appropriate. All formats were chosen to give maximum clarity to the results. The qualitative data produced from the students' feedback within sessions, open-text survey responses, facilitators' and

observers' field notes etc. were analysed using a combination of themed analysis and coding to identify key themes arising from the data.



Photograph 1: Brainstorm image and learning objectives (Year 2 PBL Session 1)

- Understand more about music therapy provision for bereaved families in the UK, with a focus on those affected by cancer.
- Gain a better understanding of bereavement processes, with a focus on the disclosure of illness and/or timescale of diagnosis.
- Explore the links between OCD, anxiety and depression.
- What is "empty-nest syndrome"?
- Has there been an increase in the number of professionals (e.g. solicitors) being referred to music therapy through GPs in the UK?

Box 1: Year 2 learning objectives generated from discussion of the Year 2 case scenario

Year 1 Case Scenario: Ben

Ben is a six year-old child who attends a specialist ASD school. He has one younger brother. Parents report that Ben met all of his developmental milestones until the age of 18 months when he began to withdraw and to lose some communicative skills. At present, he is non-verbal and exhibits many stereotypic behaviours including hand-flapping and spitting. He can become upset very easily when routines are challenged leading to an escalation of difficult behaviours including injuring others and himself through biting and pinching. When Ben is calm he is easy to engage

and appears to enjoy relaxing to music. Ben really enjoyed some recent visits by community musicians when they came to his school. His teacher feels that a Music Therapy assessment may help staff understand Ben better. She also wonders if Music Therapy could support Ben in his development of more interactive skills as well as a better way of regulating his emotions.

"Back story" for tutors and academic use: possible areas expected to be explored by students during their discussions and self-directed study:

- Autism
- Communication
- Safeguarding
- Health and Safety
- What Music Therapy approach to use with Ben?

Year 2 Case Scenario: Julia

Julia is a 50-year-old woman who works as a solicitor in a busy practice in a small town. Her husband died of cancer 6 months ago and she has 2 grown children who live and work in London who she doesn't see very often. Over the past few months she has experienced a high level of anxiety which gets worse when she is out of the house. She is not sleeping well and finds it difficult to get up in the morning. She also finds it difficult to leave the house because she has to keep checking the doors are locked. Her lack of motivation is stopping her from doing anything other than her work and her colleagues have stopped asking her to socialise with them. She has been referred by her GP to your organisation for a Music Therapy assessment.

"Back story" for tutors and academic use: possible areas expected to be explored by students during their discussions and self-directed study:

- Depression
- Bereavement
- OCD
- Menopause and empty nest syndrome
- What Music Therapy approach to use with Julia?

Box 2: Year 1 and 2 PBL case scenarios and back stories

INTEGRATION AND ANALYSIS OF DATA SETS

Overall effects as seen in Figure 1 below can be summarised briefly and will be elaborated in the discussion section. The graph in Figure 1 shows the percentage changes across all years for all the questions around aspects of music therapy clinical reasoning confidence when comparing the pre- and post-PBL survey results. It can be seen that the effects on music therapy students' clinical confidence were generally positive or neutral, with only one negative effect (Year 3, Question 5), which is discussed subsequently. In Years 1 and 2, students' confidence in several aspects of their clinical reasoning skills were positively affected by taking part in the PBL process and the effects were more pronounced in year 2. In year 3 taking part in the PBL process resulted in very little change in students' confidence in their clinical reasoning skills. There were differences and similarities across the years which are also discussed below. All year groups responded positively to the PBL process and there was a very clear message that students would like more PBL within the curriculum.

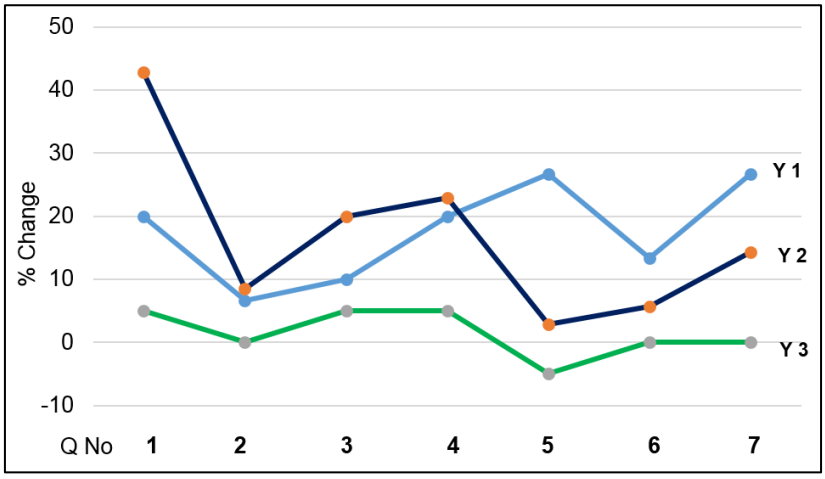


Figure 1: Comparison of the percentage change in confidence in clinical reasoning in music therapy students in Years 1-3

Year 1: Students' confidence in some aspects of clinical reasoning did increase as reported in the data. However, their open text comments expressed some concerns and confusion. Issues raised by students included confusion over the survey questions relating to their discussions, the structure of the case scenario and the design of the tasks within the PBL process. These issues were explored further with the group during a semi-structured focus group soon after the second PBL session had completed and the data from both pre/post PBL surveys was reviewed. Students were given an opportunity to elaborate on several points raised by the results in the Likert scale questions and the open text comments. The discussion was summarised and points agreed and these were circulated soon afterwards for approval and comment. Themes to emerge from the focus group discussions included questionnaire confusion, case scenario construction, issues around directed and non-directed learning and timing.

The Year 1 PBL process was enjoyed by all the group with 100% scoring 4/5 on the Likert Scale in terms of the positive effects on their learning experience. There was an overwhelming agreement (100% scoring 4/5) that they would like more PBL within the curriculum.

Year 2: Students' confidence improved in all aspects of clinical reasoning. Additionally, the PBL process was experienced as positive, with 100% of the group scoring 4 on the Likert scale in terms of the positive effects on their learning experience. 71.4% agreed that they would like more PBL within the curriculum. Very few Year 2 students chose to use the open-text boxes to comment further. Those that did indicated an interest in the project and how it was being run. After taking part in the PBL process they commented that it had been: "helpful…useful…group participation was fruitful".

Year 3: There was little overall effect on the students' confidence in their clinical reasoning skills. There was a very slight effect in three areas, no effect in three areas and a slight lowering of confidence in one area. The group was positive in terms of their learning experience, with 100% scoring 4 or 5 on the Likert scale and an overwhelming agreement (100%) that they would like more PBL within the curriculum.

The key findings were that there was a generally positive or neutral effect on the students' perceptions of their clinical reasoning skills in all years. The positive effects in Years 1 and 2 were more pronounced than in Year 3. Their results showed only slightly positive changes, one slightly

negative change, or the results were neutral. Potential explanations for the results and any similarities and differences across the three years' cohorts are discussed below.

For Year 1, taking part in the PBL process clearly improved their confidence in some aspects of clinical reasoning. The areas of confidence which improved (20/26.67%) were students' perceived abilities to use diagnostic procedures, undertake/arrange investigations and make observations and record the service-users' responses. Slightly lower increases (10/13.3%) of confidence were reported in using research skills, problem-solving skills and formulating specific and appropriate music therapy management plans. A very slight increase of confidence (6.7%) was reported in their ability to conduct music therapy effectively. Perhaps this was not surprising, as the students had not commenced any clinical work at the time they received the PBL teaching input. Despite these positive effects, the Year 1 students expressed some concerns and confusion in the post-PBL survey.

The issues raised by Year 1 students as seen above (i.e. survey-questions confusion, case-scenario structure and PBL task design) were explored further during a semi-structured focus group. It was interesting to note that while the Year 1 students were expressing concerns and confusion and felt they had not covered clinical reasoning in their discussions or SDL, they still reported improvements in all areas of their clinical reasoning confidence, albeit very small in some instances. This could reinforce Maggi Savin-Baden's views that learning is stimulated most effectively at moments of confusion and ambiguity which occur during "disjunction". Savin-Baden argues that: "disjunction is not something to be seen as unhelpful and damaging, but instead as dynamic in the sense that different forms of disjunction, enabling and disabling, can result in transitions in students' lives" (Savin-Baden, 2000, p. 87).

There was a stronger effect of the PBL process overall in Year 2 as compared to Years 1 and 3, with all areas of clinical reasoning confidence improving. An improvement of 42.9% was seen in their confidence in using diagnostic procedures. Slightly lower increases (20/22.9%) were reported in undertaking/arranging investigations and formulating specific and appropriate music therapy management plans. Confidence in problem-solving skills increased by 14.3% and lower increases (5.7/8.6%) were seen in using research skills and conducting music therapy effectively. Finally, the lowest increase (2.9%) was reported in their ability to make observations and record service-users' responses.

Student feedback in PBL session two included the following comment: "it was helpful to have background info about a potential client to help support the initial sessions, but thinking about strategies etc. was harder". A point about strategic thinking was also made by another student: "some useful points to start thinking about a case, but I struggled to come up with approach and strategies for the music therapy plan". This was reinforced by yet another: "thinking through strategies in advance was useful".

The above comments concern areas which Year 2 students have reported as being more challenging, and there were moments when the group resisted these more uncomfortable discussions. As in Year 1, however, this experience of confusion and discomfort could arise when learning is happening and transitions are being made. Taking part in the PBL process improved the confidence of Year 3 students by 5% in using diagnostic procedures, formulating specific and appropriate music therapy management plans and undertaking/arranging investigations. In the three areas of

conducting music therapy, problem-solving skills and research skills there was no change. In the area of observations and recording of service-users there was a slight decrease of 5% in confidence.

However, this year group already had higher confidence levels in areas of clinical reasoning, possibly due to their experience of two years' placement work. The pre-PBL mean total scores were seen to increase for each cohort in all but one aspect of clinical reasoning. Since pre-PBL confidence levels were already quite high in Year 3 this could explain why the PBL sessions had a less positive effect. Year 2 and 3 students are both within what could be considered the clinical phase of their studies, and Year 1 in the pre-clinical. When considering the effects on students' confidence in their clinical reasoning skills, there is no clear or obvious difference between the pre-clinical and clinical phases.

When reviewing the results graphed in Figure 1, other than positive effects in all but one case, the effects on each area of clinical reasoning skills are not consistent within or across years. However, there are some similarities, e.g. the most positive effects in all years were seen in students' confidence in using diagnostic procedures (Y1 - 20%, Y2 - 42.86% and Y3 - 5%).

EFFECTIVENESS OF THE CASE SCENARIOS AND INTEGRATED TASKS

The project also monitored how the design of the case scenarios and integrated learning tasks affected the learning process. It was found that the three case scenarios functioned reasonably well as trigger materials for discussions and generating learning objectives. As covered below in more detail, each year's discussions, learning objectives and self-directed learning activities mapped closely against the topics which were intended to be simulated by the design of the case scenarios. In all three years, generating the learning objectives was experienced as one of the most challenging steps in the PBL process.

The learning objective formulation was an activity which was experienced in a consistently challenging way across all three years. A discussion arose during this activity in Year 3 which highlighted the fact that some students were feeling uncomfortable about what they felt they were supposed to be learning, and that the case scenario wording was "ambiguous". When this was discussed further there was a moment of realisation for one student, who commented: "Is it the point that the scenario is made up and it's meant to stimulate the group getting to the learning objectives?" Again, this slightly confused and ambiguous state may have allowed students to move into new areas of learning (Savin-Baden, 2000). However, it is important to consider that students could have needed more explanation around the function of the case scenarios within the PBL process. For example, a Year 1 student commented that "it's frustrating to identify so many areas of potential questions and only have time to study some". It is also interesting to note that there was a weaker effect on Year 3 students' confidence in their clinical reasoning, and they did agree that they would like more PBL. This could be explained by the comments made which were generally very positive about the PBL process and there was a high level of engagement and enjoyment in the PBL sessions. One student summarised this when they said: "This leads to a greater engagement with study. Important to feel part of the learning process, and to feel involved and considered. The wisdom of the crowd leads to useful and interesting territory."

Despite the groups' occasional discomfort with the PBL process and severe time constraints, with perseverance and guidance, in each year the PBL group process continued to function well and several learning objectives were produced. In Year 1, the case scenario successfully stimulated discussion and SDL in several topics which include the more obvious, namely the autism spectrum and the effects of ASD on communication and other sub-topics. Further discussion and learning covered issues around safeguarding and health and safety, and started to explore how music therapy could help. When compared to the expected areas which the Year 2 case scenario was designed to stimulate, the learning objectives again mapped closely against the main topics. These included depression, anxiety, bereavement, OCD and menopause. Further discussion also covered issues such as empty-nest syndrome and isolation, and the potential value of music therapy for this client. Finally, in Year 3, the explored areas and learning objectives mapped well against the expected areas which the case scenario was designed to stimulate. The more obvious topics were explored, namely inclusivity, location, accessibility, assistive music technologies and equipment choices. Further discussion and SDL also covered issues around the causes and effects of acquired brain injury, and started to explore elements of performance and session preparation which could be used in a group with a mixture of disabilities. There were also discussions related to differing models of music therapy, such as community music therapy. These were interesting for the group to explore, as they had been trained in psychodynamic music therapy.

DISCUSSION

The case scenarios were effective and functioned well in terms of raising students' interest in, and discussions around, the topic areas or "back stories" that they were intended to (see Box 2). As has been reported previously, however, the Year 1 students felt that certain changes to the case scenario would have produced more targeted learning. One suggestion for improvement included splitting the text into two paragraphs, which would draw their attention to the more clinical aspects of the case. Making the PBL case more obvious, directive and easier for students is in direct contrast to the clear advice given when discussing the project, case scenarios in general, and the three music Therapy scenarios specifically with the head of Small Group learning and Professionalism in a UK medical school (H. Neve, personal communication, 24th January 2015). If USW is to continue to develop the use of PBL in future this will be one of the most important decision-making areas to consider. While there needs to be a balance between ensuring the PBL can fit into the course timetable, making the PBL more directive could remove one of the main points of using PBL, which is to move away from directive teaching, and into student-led learning. This was reflected in the Year 1 focus group discussion, and one student thought that there was additional learning to be achieved by identifying their own resources.

Another aspect of the PBL process which worked effectively was the introduction of the extra integrated task in Years 2 and 3. These focused clinical tasks allowed students to take the general principles they were exploring and apply them to a simulated task. The tasks were to create a music therapy plan in Year 2, and performance schedules and session plans in Year 3. Although carrying out both tasks in both years was challenging for the group, and for the group facilitation by a third-year music therapy student, in both cases steady progress was made and students were able to eventually

see the rationale behind being asked to engage with these integrated tasks. In Year 1, where students were deliberately not given a clinical task, all students felt they would have benefited from a similar integrated clinical task. When designing integrated clinical tasks there could also be an opportunity to link them closely to music therapy settings, current placement experiences, and other curriculum areas (e.g. clinical improvisation sessions). As reported by Nochamma Sockalingham et al. (2011), effective problems should lead to formulation of appropriate learning goals, relate to the students' prior knowledge and be interesting. The three case scenarios developed and used in this project met all these criteria.

Feedback from the course leader who observed all PBL sessions was invaluable in articulating the outcomes of the project. She reported that it was illuminating to see the level of engagement promoted by this pedagogical method. Students were able to engage in the way that suited their learning styles. For example, some students undertook the role of the scribe, and indicated they found this method of participation stimulating. Some were more active in SDL that was then presented for discussion the following week. It was useful to see students' thought processes in action as cases were discussed and reflected upon. The role of the PBL facilitator also appeared to align well with pedagogical aspects of music therapy teaching, where the seminar or experiential leader may be more akin to that of facilitator than teacher. Also of value was the fact that a clear maturity of thought and emerging professional personas could be seen, particularly in the Year 3 students. Here there was a shift towards evaluating different music therapy methods and seeing how alternative ways of practising could meet service-users' needs.

Student feedback and quantitative data gathered from this pilot led USW to consider the continued use of PBL across all years of the music therapy MA, building upon the pilot study's experiences and findings. More consideration could be given to continuing the PBL pilot in all years, or with a focus on Years 1 and 2, as well as developing online resources to support the method. The existing cases could be developed, including possible digital enhancement. Integrated clinical tasks could also be woven more securely into the PBL seminars. The project essentially threw the students into the PBL process, and there could be merit in developing an introductory PBL case scenario as an induction to the PBL process. As with any academic input, careful consideration needs to be given to avoid the PBL seminars clashing with other course deadlines.

On implementation of further PBL in the MA Music Therapy training at USW, it would be vital to continue to evaluate its effectiveness on clinical reasoning or other skill sets together with the student experience of the pedagogical method. There would also be the possibility of developing a music therapy PBL evaluation tool, with a view to possible future collaboration with other music therapy courses. The PBL process has already been integrated at USW with other educational activities, such as clinical improvisation and theory and practice seminars. Initial responses and outcomes to these curriculum developments are positive. Further staff training in PBL facilitation and expertise would be desirable to build on the findings of this pilot. Although at present these methods are only used in the MA Music Therapy, it would be worth broadening its usage to the MA Art Psychotherapy programme, as well as potentially using mixed groups of trainee music therapists and art psychotherapists. Laahs and Derrington (2016) have written of the benefits of interprofessional education (IPE) with reference to the MSc Music Therapy programme at Queen Margaret University in Scotland, so there is an emerging evidence base for this kind of work. It could also be beneficial to make contact with other

UK music therapy programme leaders and academics to find out more about their use of PBL with a view to possible future sharing of case scenarios and pedagogical research. In an international context, Clark and Thompson (2016) write of the challenges of delivering e-learning in their MA Music Therapy programme at the University of Melbourne. Perhaps PBL could be considered as a mode of curriculum delivery here, for intensive study weekends or group discussion via online personal interaction. Further research could explore how the confidence level reported in music therapy students mirrors changes in their practical work.

CONCLUSION

In conclusion, and with full acknowledgment of the inherent limitations of a self-reporting evaluation, this project successfully piloted the use of PBL in music therapy training across the three years of the MA Music Therapy programme at USW. The experience gained for the teaching team and students, and the research data obtained, has provided evidence of positive effects on music therapy students' confidence in their clinical reasoning skills and upon their learning experiences. The information is useful in itself to add to the body of knowledge around PBL and its effectiveness in aspects of music therapy training, but it can also be used to inform future decisions on further use of PBL within USW. Given the positive effects coupled with the information on how the implementation of any PBL intervention can be influenced by a variety of controllable factors, there is every reason to conclude that future use of PBL within music therapy training at USW and at other institutions could be highly effective.

APPENDIX: PRE-/POST-PBL SURVEYS

Pre-PBL survey Year … SURVEY NO …

PBL and music therapy: A pilot study at USW: 2014/15

Please choose the options which are closest to your opinions in all the questions below.
Please tick the relevant boxes to indicate where on the scale you agree or disagree with the following statements.

Q1: I feel confident in my ability to conduct appropriate diagnostic procedures effectively.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q2: I feel confident in my ability to conduct appropriate music therapy effectively.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q3: I feel confident in my ability to formulate specific and appropriate music therapy management plans, including the setting of timescales.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q4: I feel confident in my ability to undertake or arrange investigations, for example setting up an assessment period in order to ascertain the appropriateness of an intervention.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q5: I feel confident in my ability to observe and record service-users' responses.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q6: I feel confident in my ability to use research skills to determine appropriate actions.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q7: I feel confident in my ability to use problem-solving skills to determine appropriate actions.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q8: I anticipate that taking part in the music therapy PBL sessions will have a positive effect on my learning experience.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q9: I have been involved in problem-based learning in a previous educational setting.

☐ Yes ☐ No

Q10: Further comments: Please use the area below for any feedback or comments which you feel are important, relevant, or which you think we should know about before you take part in the PBL group.

Thanks very much for completing this survey and being part of this research.

Post-PBL survey Year … SURVEY NO …

PBL and music therapy: A pilot study at USW: 2014/15

Please choose the options which are closest to your opinions in all the questions below.
Please tick the relevant boxes to indicate where on the scale you agree or disagree with the following statements.

Q1: I feel confident in my ability to conduct appropriate diagnostic procedures effectively.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q2: I feel confident in my ability to conduct appropriate music therapy effectively.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q3: I feel confident in my ability to formulate specific and appropriate music therapy management plans including the setting of timescales.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q4: I feel confident in my ability to undertake or arrange investigations, for example setting up an assessment period in order to ascertain the appropriateness of an intervention.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q5: I feel confident in my ability to observe and record service-users' responses.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q6: I feel confident in my ability to use research skills to determine appropriate actions.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q7: I feel confident in my ability to use problem-solving skills to determine appropriate actions.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q8: Taking part in the music therapy PBL sessions has had a positive effect on my learning experience.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q9: I would like more of the music therapy curriculum delivered using a PBL approach.

Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
☐	☐	☐	☐	☐

Q10: Further comments: Please use the area below for any feedback or comments which you feel are important, relevant, or which you think we should know about now you have taken part in the PBL group sessions.

Thanks very much for completing this survey and being part of this research.

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Ελληνική περίληψη | Greek abstract

Προσφέρουν οι προσεγγίσεις Μάθησης με Βάση το Πρόβλημα [Problem-Based Learning] αποτελεσματικές εκπαιδευτικές παρεμβάσεις για τα εκπαιδευτικά προγράμματα μουσικοθεραπείας? Εμπειρίες από μια έρευνα δράσης στο Πανεπιστήμιο της Νότιας Ουαλίας

Sally Holden | Elizabeth Coombes | Kathy Evans

ΠΕΡΙΛΗΨΗ

Μια προσέγγιση Μάθησης με Βάση το Πρόβλημα [Problem-Based Learning, PBL] δοκιμάστηκε πιλοτικά σε όλο το μεταπτυχιακό πρόγραμμα μουσικοθεραπείας στο Πανεπιστήμιο της Νότιας Ουαλίας. Ο κύριος στόχος του προγράμματος ήταν να διερευνήσει κατά πόσον η ανάπτυξη των πρακτικών δεξιοτήτων και της ικανότητας κλινικού συλλογισμού των φοιτητών μουσικοθεραπείας θα μπορούσε να ενισχυθεί με τη χρήση μιας προσέγγισης PBL κατά τη διάρκεια των σπουδών τους. Μελέτες περίπτωσης οι οποίες ενσωματώνουν

πολλές πτυχές της απαιτούμενης μάθησης καλύπτοντας βασικούς τομείς του προγράμματος σπουδών αναπτύχθηκαν και χρησιμοποιήθηκαν σε συνεδρίες PBL με κάθε ομάδα φοιτητών. Οι συνεδρίες συντονίστηκαν από έναν συντονιστή με κατάρτιση στο PBL και εποπτεύθηκαν από τον υπεύθυνο του προγράμματος μουσικοθεραπείας. Οι φοιτητές ολοκλήρωσαν ένα ερωτηματολόγιο πριν και μετά την εφαρμογή του PBL, δίνοντας πληροφορίες σχετικά με την αυτοπεποίθησή τους σε διάφορους τομείς του κλινικού συλλογισμού. Συγκεντρώθηκαν επίσης σχόλια σχετικά με τις απόψεις τους σχετικά με την προσέγγιση PBL και τις επιπτώσεις της στη μαθησιακή τους εμπειρία. Τα αποτελέσματα δείχνουν ότι η εμπλοκή με τη διαδικασία PBL είχε θετική επίδραση στην αυτοπεποίθηση των φοιτητών ως προς τον κλινικό τους συλλογισμό, και στην θετική τους αξιολόγηση αυτής της εμπειρίας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Μάθηση με Βάση του Πρόβλημα [Problem-Based Learning], δεξιότητες κλινικής σκέψης, εκπαίδευση μουσικοθεραπείας, έρευνα

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REFLECTIONS ON PRACTICE | PEER REVIEWED

We All Came From Somewhere

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Abstract

This reflection on practice concerns a short-term music therapy project undertaken in 2014 with asylum seeking families in a major city in S. Wales. The project was designed to support these families in settling in their new home, and was the first music therapy initiative for the charity who funded it. The work itself caused the therapist to reflect on the countertransference engendered by the experience and how this aspect of the work enabled her to gain a deeper understanding of issues faced by those who find themselves seeking asylum in another country.

Keywords: *music therapy, asylumseekers, countertransference, reflection*

Prelude

In 2014, I led an 8-week music therapy project for asylum seeking families with preschool children. The work was located in a major city in South Wales. Funding was provided by a large UK charity dedicated to improving the lives of the most vulnerable children and young people in society. The purpose of the work was to make connections between newly dispersed asylum-seeker families and the charity and to assist them in becoming part of their new community. The charity was interested in broadening the range of therapies it offered and wanted to use unallocated funds to explore the option of music therapy.

The original idea for the project had developed from a chance meeting with a manager of part of the charity's provision. We had met at a play therapy clinic opening and had discovered a mutual interest in developing services for asylum-seeking families. There was at the time a paucity of therapeutic support for this population in the city. My thinking around the difficulties of transitioning to a new country and culture and how music therapy might play a part in supporting this population piqued the manager's interest. A few weeks after the meeting, I received an email from the charity asking me to devise a short project for the client group mentioned above, and I began to seek out ideas and frameworks to help me think about this work.

Although I had experience in working using music therapy and skillsharing in the Occupied Palestinian Territories (OPT) (Coombes, 2011; Coombes & Tombs-Katz, 2017), I had not worked in my own country, Wales, with the asylum-seeker population. I located a body of literature discussing music therapy and music work in this area of practice in a multitude of geographical locations (Behrens, 2012; Storsve, Westby, & Ruud, 2010; Sutton 2002). There were descriptions of work in clinical, community and school settings in the countries into which refugees (for so they were designated in these papers) had been placed (Choi, 2010; Jones, Baker & Day, 2004; Orth,

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2005; Signorelli & Bright, 2006). Whilst these were of interest in that they discussed matters relevant to the population in general, it was not until I located the writing of Zharinova-Sanderson (2004) that I began to gather my thoughts in a more coherent manner. She talked about the potential for musicking with this client group to build trust and community engagement, moving from a position of social isolation to one of integration. Her thinking appeared to support the needs of the target client group for this pilot: asylum-seeker families with young or pre-school children.

As well as the immediate issues of settling in a new community, there were also the well established frameworks of attachment theory to consider (Ainsworth, 1963; Bowlby, 1969). It seemed that due to the pressures of the situation in which they were living, some caregivers may have been struggling to be emotionally accessible to their children. This could disrupt the early relating experiences so important for the child's development and relationship between carers and child. There seemed to be links showing the potential for the development of healthy attachment styles and music therapy work which supported my position (Pasiali, 2012).

There is a wealth of writing on the topic of musical connections with parent-child interaction and bonding. Amongst others, Abad and Edwards (2004) discussed the inviting nature of such interactions; Oldfield, Adams and Bunce (2003) described how using music could be seen as a natural extension of communication between parent and child. Oldfield and Bunce (2001) also suggested that short-term music therapy with mothers and children can be an effective treatment for certain client groups. There was, then, the potential for this model of structured sessions with social time for conversation after sessions to be a useful framework for this pilot.

I was also mindful of my own position as insider/outsider in the work. As a Welsh music therapist, would the clients' perceptions of me as an authority figure impact negatively on their experiences in the group? What was I bringing to the group musically and in terms of preconceived notions, perhaps? Bridges (2001), writing about what he described as outsider research, posits that only those who have been part of a particular experience can understand that experience. He also suggested that utilising existing frames of reference relevant to the outsider themselves and their culture may actually be damaging to the work being undertaken. My background as a psychodynamically trained music therapist, with experience of the model of infant observation developed by the Tavistock Clinic in London, seemed incredibly foreign to the worlds of the asylum-seeker families. However, my previous work in the OPT, in which I had utilised these very frameworks, as well as those of Winnicott (1960, 1971) and Stern (2001), had provided a useful underpinning for my thinking. Whilst it was imperative to be mindful of these matters, I felt I could work in an appropriate way with these families and offer them a useful experience in what was to be their new home.

I was allocated a support worker to assist me during the sessions. Gemma was a primary school teacher by training and was now working for the charity. She was to make the practical arrangements associated with the project, including locating the families, arranging the initial meetings and weekly session times. It was the first project she had set up and worked on in this position. Our first task, once the families had been offered a place on the project was to meet each of them individually in their homes, before the work started, to build up a rapport. We wanted to offer a personal touch to what otherwise could have seemed a rather intimidating invitation by letter. None of the families offered the project contained a male figure, so the group in the event was a mother-child group, with two mothers bringing two children with them to the group.

The first home visit

> It was a clear, cold, breezy day in January when we drove across town, heading south and passing under the railway track. There were rows of terraced houses, small shops, and curving streets that pulled you in different directions.

We squeezed the Fiat Uno into a parking space and climbed out, blinking in the sunlight and shading our eyes to read the street names. I carried a bag of percussion instruments meant to invite and entice. Gemma packed a sheaf of papers, permission slips and explanations translated into several languages. We were prepared.

Or were we? Disorientated, we turned around, craning and twisting our necks. The wrong street - or was it? The name was almost right. The house numbers weren't in order; some were missing. A nagging feeling crept over me, like something picking at the back of my neck. This wasn't the address, but it had to be. We checked our watches; we mustn't be late. Gemma took action and started knocking at a door that had a number near to the one we were seeking. No answer. Anxiety rose in my stomach. I crossed the road and stood in a patch of sunlight allowing the warmth to fill my body. There was a bakery on the corner. The smell of freshly baked goods wafted over to us. I entered and asked for the address. “Oh yes, love. It’s a new build. Just behind here. Hard to find. Everyone misses it”. It wasn't on the map. No way to tell. No way to know we were nearly there. We had to ask.

Relieved, I called to Gemma, and we walked the few steps to the small mews houses tucked away in a cul-de-sac. The house numbers were plain to see. We took a breath and knocked on the door.

Reflections

Feelings of “being lost” were very present for me throughout this project. At the time, while the work was ongoing, it was hard to think about this, hard even to identify it in the moment. It was as though in order to work with the group, these feelings had to be managed and held well enough to continue the music therapy. Perhaps there was something unbearable about them. It seems now, some time later, that these emotions were an important part of the countertransference not only for this particular piece of work, but also potentially for the client group of asylum seekers itself. It is interesting to note, however, that those who have worked with and written about their experiences with asylum-seekers do not reference this particular aspect of the work in any detail.

Mary Priestley (1994) emphasised the importance of using countertransference responses to deepen understanding and direct the responses of the therapist to the clients’ material. She identified two kinds of countertransference, both of which must be worked with to enable the therapist to work effectively. Empathic countertransference (E-countertransference), where the therapist develops a psychological awareness of the processes at work through an empathic identification with the clients, served to allow me to experience these feelings and use them as a frame of reference for this work. Her description of these feelings as a form of resonance supported me in staying with this work in an emotional sense, as at times, it felt very difficult to remain present with the group. The complementary countertransference (C-countertransference) occurs where the therapist identifies with strong relationships from the clients’ past. Here I felt there was an ambivalence present for the families. Although we had few details about how the families had arrived in the UK, the bits and pieces of information we did have showed a fragmentation of family life. While it seemed that there were positive relationships in the past, there were also some other more troubling aspects of their lives that seemed omnipresent. In this group setting, it seemed that the families were working towards providing nurturing relationships and environments for their children. It was important that I continually check-in with myself by remaining curious and vigilant as to my interventions and the communications I made with the group. By working with this construct, I felt that even in this short pilot, I was able to support the mothers to work with their feelings and feel supported by the project. It also seemed that I was able in some way to be part of their experience, despite Bridges (2009) discussion of the impossibility of this for the outsider.

On that first day of the project when we met further members of the asylum-seeker family group, “being lost” became a thread woven through the fabric of the encounters. The second home we visited was also challenging to access. Although we could see the house, somehow we couldn’t work out how to gain access to the parking in

front of it. We ended up driving round in circles, glimpsing it a number of times before we could see how to draw nearer and park outside. The third home had two front doors on different sides of the house. We spent 20 minutes knocking on the wrong door before realising there was in fact another entrance. At the end of the day, we were exhausted; I wanted nothing more than to be in my own home, surrounded by familiar belongings and people. I felt a strong sense of dislocation after a day spent visiting three recently resettled families, and this needed to be countered by self-nurturing experiences to bring some balance to the day.

The symbolic meaning of these practical struggles to access the clients and "being lost" in the process was a very powerful one. Thoughts explored when devising the project were to introduce families to the culture of Wales, their new home, while reciprocally learning about their indigenous culture. Each of the families had children in school or about to access school, and part of their experience would be learning Welsh and being taught Welsh songs. This project, then, could form a bridge between the worlds of their indigenous culture and their new home, as suggested by Scroope and Signorelli (2010). Freeman-Sharpe (1978) discussed the power of curiosity in developing psychological understanding from the point of view of therapist and client. This was something I strove to maintain, as for me it signalled an openness to learn and experience, something I was hoping the families would also feel. Ansdell (2014) wrote compellingly of the importance of belonging in a community and how 'musicking' provides an opportunity for this to happen. Somehow, my feelings had to be contained and transformed to enable me to engage and attune with the group, assisting them to move towards a position of hopefulness about their current situation. Using Priestley's countertransference framework undoubtedly supported me in my way of working, offering guidance and support when at times the turmoil in the group felt too chaotic to work with.

As the short project progressed, moments of being 'in-tune' with each other developed; one child brought some exuberant Albanian folk dance moves to the 'Move to the Music' section. On another occasion, rhythms akin to those familiar to the family from Pakistan emerged with ululation and hand clapping as we improvised together. Questions about the Welsh foods we offered in the tea and cake time after the music led to curiosity about each other's cuisine. Common ground was emerging, and families began to arrive by bus or on foot, declining our offers of taxis to help them attend the sessions. They were finding their own way, and so were we.

Nonetheless, the group was still fragile. The Albanian family missed one session, and the following week we discovered that they had got off at the wrong bus stop. They had wandered around the area not being able to find the centre; the 3-year old sobbing and fighting his mother with disappointment, the 8-week old baby screaming in the pushchair. She hadn't felt able to ask for help and had only just managed to find her way home in time to pick up her other children from school. In that week's session, the soft, quiet music that often arose near the end, where families had time to cuddle and be together without words seemed very important. The intrusive reminder of the delicate state of the families was a sobering one; it hung over the group like a cloud that day and remained long after the session had ended. The sense of fragility was real; many families had been moved to different cities multiple times, and although they were now regarded as settled in Wales while their refugee status was determined, they shared their thoughts that any day, for some reason, any reason, no reason, they could be moved again.

When the 8-week project ended, we presented each child with a certificate of achievement, detailing special moments in the group. An 18-month-old boy was praised for 'good listening'. We remembered his face shining and beaming as he watched his older brother playing with the castanets, his own fingers grasping at them as his mother supported him. Another certificate mentioned kindness to the very young baby girl in the group; one boy had been very rambunctious at the beginning of the project but had been able to show tenderness towards younger members. The mothers were very appreciative of these offerings.

As for the mothers themselves, they cried during the last session. They all said how important the home visits at the start of the work had been. They had given them a sense that we, the therapist and project worker were ordinary people, eager to learn about their culture. They felt the city could be their home too. It was very moving to hear these words.

Conclusion

Although the music therapy project had ended, the charity offered the families other ways of engaging. There were trips that the families could join, and other general play groups the charity ran that they could access. They were all keen to continue meeting at the centre and this seemed to bode well for future work with the families.

The charity was preparing an evaluation of the project, but I was never to see this. Gemma was going on maternity leave at the end of the week in which the project finished, and in fact this last session was the end of my involvement with the families and this project. Despite attempting to access the final report, it was not forthcoming. I wondered if it had in fact ever been finalised and signed-off. Funding issues meant the pilot, which we all felt had fulfilled its aims of improving community engagement and supporting families as they began to make connections with the area, was never repeated. In one sense, then, the families were lost to me. The work itself seemed to have vanished as swiftly as it had arrived.

The project itself, however, did validate the theoretical approaches and frameworks I chose to use. My own psychodynamic training was of use in my reflections and supervision in unpicking the countertransference and working with the emotions present in the group. Oldfield and Bunce's (2003) project work gave a model for my own, and I felt that there was room for this model to develop. In writing this article, I came across a paper by Comte (2016), and this has given me food for further thought regarding the frameworks we ourselves import into work with this client group. There is further thinking and writing to be done to explore these matters.

For myself, 3 years later, I still find it hard to shake the feelings of disorientation and of being off-balance that this work evoked. What was striking at the time, and remains so, is that some level of a commonality of experience between the group and myself emerged. Being lost, not knowing where to go; these moments were powerful and have now woven themselves into my world-view and inform my work with this client group. As the poet Benjamin Zephaniah ("We Refugees", 2017) wrote:

> We can all be refugees
> Sometimes it only takes a day
> Sometimes it only takes a handshake
> Or a paper that is signed.
> We all came from refugees
> Nobody simply just appeared,
> Nobody's here without a struggle,
> And why should we live in fear
> Of the weather or troubles?
> We all came from somewhere.

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Research Into Practice: Exploring How Personal Interests Can Shape Practitioner Identity

Liz Coombes, Fiona Bryant, Paul Morgans, Kelly Taylor, Richard Trethewey and Beth Pickard

University of South Wales
Prifysgol De Cymru

This poster explores how the motivations and personal interests of student music therapists can shape their research interests and subsequent practitioner identities. Ensuring that students engage in research and evidence-based practice as part of their training is a requirement of the HCPC Standards of Proficiency (HCPC, 2013), and focusing this research on an area of personal interest is advocated by Ansdell and Pavlicevic (2000) as a motivating force. As music therapy students begin to develop their own therapeutic identities and personas, it can be important for them to recognise and work with those areas of practice which stimulate interest for them personally (Burns and Meadows 2017). The cohorts of student music therapists entering training programmes are becoming increasingly diverse in their musical and professional identities, and their motivations to study are increasingly multifaceted (Goodman, 2015). The impact of this rich tapestry of motivations is apparent in the range of research interest explored for the dissertation project on the MA Music Therapy programme at the University of South Wales. While there is some research on the motivation of music therapists to practise (Lee, Davidson and McFerran, 2016) and of the influence of existing musical identities on therapist identity (MacDonald, Hargreaves and Miell, 2002; Loth, 2006; Amir, 2012) the evolving identity of cohorts and the impact of their increasingly wide ranging motivations on their research endeavours is an area of interest and focus for this poster. As Hoskyns (2013) proposes, integration of meaningful research practice into training programmes is vital to develop the next generation of researchful practitioners.

Good Vibrations: An Investigation into the Possible Integration of Elements from the Sound Healing Tradition into a Contemporary Music Therapy Practice

"My background in sound healing had already given me an awareness of the positive physical and emotional impact that listening to specific tones and frequencies can have on the body. What piqued my interest in music therapy, however, was the added psychotherapeutic dimension that it brings to the relationship between the client and the therapist. Sound healing, in the main, is a receptive treatment with little or no interaction or reflection. During the course of my music therapy studies, I came to wonder whether, for some client groups, "being done to" might be perceived as a less threatening way of commencing treatment than immediate musical interaction. Would it be possible, on an individual client basis, to introduce elements of the sound healing tradition into my future practice as a music therapist? Although my dissertation research soon revealed that I was sailing in relatively uncharted waters, it has also inspired me to carry out further investigations post qualification."- Fiona Bryant

Using Electronic Music Technology Therapeutically: How Do UK Music Therapists Become Skilled in its Clinical Uses?

"I discovered a passion for music technology whilst studying for my undergraduate degree. Taking a subsidiary class in electroacoustic composition led to me changing my major from traditional to electronic music! The use of technology to create and share music continued to intrigue me as I began teaching and working with children with PMLD. Technology use here became very important, it allowed my students to access music in new and exciting ways. Whilst undertaking the MA Music Therapy, the use of music technology was still in the forefront of my mind, so it became an obvious choice for my dissertation topic. Personally, I was privileged to have training in how to create music using technology by some of the pioneers of the electroacoustic field, but not everyone has this kind of access to a music technology education. I began to wonder, if a music therapist holds an interest in the use of technology, how could they become educated and skilled in its clinical uses?" – Kelly Taylor

Reading the words of the 4 students relating to the research areas they pursued for their dissertations, it is clear there was a great diversity of interests explored. Previous life experiences, whether educational or professional, evoked a curiosity in specific areas of music therapy practice. Indeed, for some, it was these areas that actually encouraged further study in the area of music therapy practice in the first place. As music therapy students begin to develop their own therapeutic personas, it can be important for them to recognise and work with those areas of practice which stimulate interest for them personally (Burns and Meadows 2017). Although the sample of work interrogated for this poster was small, it is possible to identify themes emerging that may contribute to the development of a robust practitioner identity.

Theme 1 - Previous Life Experience *This is described by Morgans and Trethewey. In Morgans case, his previous career as an actor gave him insight into the value and potential meaning of silence. He was able to understand that silence had the potential to hold many emotions and be expressive of a client's state of being. Trethewey had pursued a personal performative interest in the folk music of his native Cornwall, and this inspired him to explore elements of identity for clients and therapists.*

Theme 2 - Previous Formal Educational Experience *This aspect is referenced by Taylor and Trethewey, both of whom pursued undergraduate degrees in subjects that later became the focus for their MA dissertations. The specialised nature of these interests led them to align their academic work with previous knowledge and in fact deepen their understanding of these areas of study by linking them to music therapy.*

Theme 3 - Previous Interests/Training Related to Wellbeing *Bryant had undertaken vocational training in Sound Healing, and it was this that had sparked her interest in music therapy. She was struck by the importance of the therapeutic relationship in music therapy, as opposed, so it would seem, to the more receptive nature of Sound Healing. She began to interrogate the potential for integrating the 2 practices as a means of engaging clients who may have been challenged by the idea of interactive music therapy.*

The students' research areas and eagerness to investigate their chosen subjects with curiosity, demonstrated that this, together with an existing passion, fuelled the research and production of a final dissertation. As Hoskyns (2013) states, 'fire and curiosity' ensure the student is invested in their practice area. Ensuring training programmes foster this together with robust teaching and supervision in the area of research and practice is clearly an aspect of the training that is of great importance to the quality of our practitioners

An Exploration into Music Therapists' Perceptions of Using Traditional Music with Clients Living with Dementia

"Folk music has often been described as music of the people and even as a possession to be cherished. I grew up interested in the cultural history and identity of Cornwall and the Cornish people which led me to cherish the traditional music of Cornwall and beyond. I studied for a BMUS on the Newcastle based Folk and Traditional Music degree and it was here I put together a collection of songs that represented the industries that were associated with my home and in turn my own family history. Four years later I was studying for my Music Therapy MA and was on placement with the Methodist Homes Association in a dementia care home in Cornwall. It was this that sparked my interest in using folk music linked with where a client felt they were from and the possibility of strengthening their sense of themselves and their unique identities."– Richard Trethewey

When the Music Stops: An Interpretative Phenomenological Analysis

"As an actor, I have known that the silences that surround the words you speak on stage and on film can be as important as the words themselves. Through manipulating the silences both in time and intensity, it is possible to create and deliver feeling and meaning to the listener who is left to interpret. Perhaps then, it was no surprise that this previous knowledge and experience of silence, which I acquired over a decade of performing, whilst training to become a Music Therapist was once again utilised. In therapy sessions, I became very aware of the silences that occurred within the musical encounters of my clients. I found the silence that was created between us could be as full of expression and meaning as the sounds that were made. And it was this connection with silence in both areas of my work and training, where my interest and subject for my third-year MA Music Therapy dissertation was created."– Paul Morgans

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Let Your Passion Be Your Purpose – Elizabeth Coombes and Beth Pickard, University of South Wales

"Your passion will lead you to your purpose" (Bishop T.D. Jakes)

This poster illustrates the variety of interests that may be developed as research projects by MA Music Therapy students at the University of South Wales. It speculates as to the value of following one's passion in this work, suggesting this is an important part of meaningful research. The teaching team's own research interests also nurture the students' researchful capcity and support the trajectory of their informed practice endeavours.

Sound Healer

Singer

Parent

Folk musician

Fiddle Player

PBL

Composer

Music Technology

Actor

Early Years

Ansdell and Pavlicevic (2000) suggest that practitioners may do well to select an area of personal interest for their enquiry, as this may prove a motivation and inspiration to the endeavour.

As dissertation supervisors, we have noticed that it is often pre-existing interests, *passions*, if you will, that evoke the most effective and considered dissertation submissio

Teaching staff embody this ethos of *passions* fuelling their research interests and ideas, and share this outlook through the teaching, supervision and pastoral support.

USW

MA Music Therapy

Research Practice

Psychodynamic music therapy, international practice (Coombes, 2018)

Person- Centred, Non-normative practice (Pickard, 2018, In Press)

HCPC Theory Ethics

Areas of research interests amongst students and professionals are often those which arouse a personal as well as professional interest. When music therapy students begin to develop their own therapeutic personas, it can be important for them to recognise and work with those areas of practice which stimulate interest for them personally (Burns and Meadows 2017).

Dissertation consulting practitioners on the potential of incorporating Sound Healing in Music Therapy practice

Dissertation investigating how music therapists learn to use technology

Dissertation exploring the use of folk music with music therapy clients living with dementia

Research on problem based learning published (Holden, Coombes and Evans, 2018); supervising current students

Pursuing their *passion* through the research and dissertation module has enabled several students to develop an informed specialism, which they go on to share with others through publication and supervision, nurturing the next generation of practitioners.

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Research Article

Betwixt and between: Considering liminality and rites of passage in the context of music therapy in a specialist further education college

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ABSTRACT

The case load of a music therapist may contain much work with young people with profound and multiple learning disabilities (PMLD) and autistic spectrum conditions (ASC) as they transition to adulthood. There is however, no extant body of work exploring the anthropological theories of liminality and rites of passage in this context. It is considered that these theories offer a potential model of working in an educational setting as these young people move into the next phase of their lives. Discussion of the above theories and a description of the setting and the connection between the two is used to propose a potential music therapy model for work with this population at this point during the clients' lifespan.

Introduction

This paper explores how the anthropological theories of liminality and rites of passage developed by Van Gennep (1960) and Turner (1969) can impact on music therapy work with young people with Autistic Spectrum Conditions (ASCs) and Profound and Multiple Learning Disabilities (PMLDs). It explores the development of a music therapy model in relation to transitioning from child to adult services for this client group. The clinical work that informs this paper took place in a specialist further education college for young people between the ages of 16–19 with ASCs and other learning disabilities. A small number of students were referred to music therapy to support them in their learning needs should their funding packages and referral criteria allow for the provision of this intervention. A significant part of the input at the college is related to transitioning to adult life, involving preparation for living in the community once students have left college.

Literature review

Liminality

Although Turner's work on liminality (1969, 1973, 1982) is widely cited in a variety of contexts, it was Van Gennep (1873–1957) whose writings around rites of passage ceremonies (1960) laid the ground for Turners's later work. Van Gennep examined rituals and transitions in homogenous pre-industrial societies, positing three phases in which he likened the processes of rites of passage to a journey:

1 Separation from the present state
2 A liminal state
3 Completion of passage and return.

The meaning of liminal in this paper derives from the Latin limen, meaning a threshold, and suggests being between one place and the next. Van Gennep explored the universality of ritual, specifically in the context of rites that involve moving from one life situation to another. There was an emphasis in the situations he studied on those moving from childhood to adulthood, a developmental stage that resonates with this particular paper. It was Turner who focussed attention on the period of transition, the liminal state. He wrote of this period as 'a becoming…. even a transformation' (1967 p. 94). Those journeying in this way may be said to be 'in another place' (p. 98), although this is not necessarily meant as physically being so; it is more a state of transition and openness to exploration of new ways of being.

The idea of liminality is one that has been explored in writings about music, music therapy and education. Ruud, a musician and music therapist (1995) wrote about improvisation in jazz, comparing and contrasting this to music therapy practice and rites of passage. He describes both processes as a liminal experiences. He refers to improvisation itself as being a 'transitional ritual' (p. 93) where in making music we may 'transcend previous borders of freedom' (p.97). In Ruud's world, this leads to Turner's 'communitas', a place where there is a sense of previous fixed roles such as teacher and pupil, or therapist and client, being removed and an equality of engagement arising. The music-making becomes the common work in which all are engaged, a place where 'music may express what is feared or hidden by the

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language and intellect'. (p.105).

Other writers have also used the idea of liminality to explore ritual process in music-making and music therapy. Boyce-Tillman (2009) wrote of the spiritual and transformative qualities that may arise for participants taking part in musicking, here used in the sense of making music, in an educational context, something she describes as creating a liminal space. She believes the space allows for 'imaginative possibilities' (p.192), and describes it as entering another 'time/space dimension' (p.192). Kenny also uses the idea of liminality as being a threshold, a door through which one steps, when setting out her 'Field of Play' theory of music therapy (2006). She allows for a more abstract interpretation of the idea of a space, calling on Winnicott's idea of a 'transitional space' (1971) to illustrate her construct. Yet in both authors' work, there is no sense of a rite of passage, more of the space itself allowing for new ways of being to be explored.

Atkinson and Robson (2012) examined the idea of liminality in an educational setting. They arranged a series of arts-based sessions in two primary schools involving a variety of artistic activities. They discuss the transformative power of such projects as being practices of liminality, where the constraints of everyday life and those of the setting are removed by engagement in the task. This is somewhat akin, perhaps, to the way Boyce-Tillman experiences and describes the act of musicking.

In none of these writings, however, is the explicit and original meaning of liminality, as linked to rites of passage discussed. It may be, however, that the sense of ambiguity as one moves from one position to another is acknowledged and seen as important in the liminal state as is the return to everyday life once the rite of passage is completed.

Exploring the idea of rites of passage and liminality as one way of examining the dynamic mechanisms at play during periods of transition has led Janusz and Walkiewicz (2018) to posit a matrix vital to the stability of persons life. They suggest the following three stages that they believe are necessary for the development of a healthy self:

1 Preserving the linear sequence of life events
2 Recognition that moving into another life-stage can be marked by a 'temporary disintegration' (p.157)
3 The potentially performative nature of the transition point to regulate emotion and identity formation

This work, however is not related to the creative arts or therapies, nor does it specifically mention an specific client group. However, it is of interest in that it is but one of a handful of writings specifically examining this area of thinking and relating it to contemporary society.

Rites of passage

It can be seen from the above that rites of passage are considered of primary importance by Van Gennep and Turner when examining the movement between different stages of life. Kimbali (p.vii 1960) describes these as being 'ceremonies accompanying an individual's life crises', and goes on to explain that the real interest for anthropologists lies not in the actual rites themselves, but in the 'essential significance' to the life of the person experiencing the rite.

Coles and Coles (2001 p.587) describe rites of passage rituals in West Africa including young boys being 'spirited away by older men to an isolated grove deep in the forest. There they are taught the secret lore of the men…When they emerge…they have a new name and a new identity'. With regards to these rites, the idea of the liminal threshold refers to the time when the young person is in a period of isolation, lingering in the space between that of childhood and adulthood. It is during this period that the preparation and instruction occur that will enable the young person to take their place in the adult world. Often, these rites are surrounded with secrecy (Van Rooyen, Potgieter, & Mtezuka, 2006) with those participating warned of dire results such as madness if they reveal any detail of what takes place during these ceremonies.

Erikson (1968) describes the period of moving from childhood to adolescence and from adolescence to adulthood as a critical part of identity formation. Here processes such as identification with aspects of others, individuation and integration of new characteristics into a personal identity take place. Rites of passage commonly associated with these processes that we may be familiar with today could be religious ones such as the barmitzvah/batmitzvah, or events that have a basis in the values and traditions of the society in which they take place such as the quinceanera, attending a high school prom, or a first gig or festival with one's peers. These events may seem far-removed from the tales of young men being sequestered in a forest undergoing a series of ritual tests, but they may nonetheless be considered as forming part of the same continuum.

Literature makes it clear that music forms an important part in rites of passage events specifically for this age group (Kenny, 2006; McFerran, Derrington, & Saarikallio, 2019), although it should perhaps be mentioned that the term 'rites of passage' itself is not mentioned in the texts. White (2019), however, writes about 'musical tribes (p.140) when she discusses the formation of music-based peer groups facilitating identity formation. Equally, Cross and Fletcher (2009) describe how young people begin to identify with their peer group through similar musical interests, while Green (2008) has explored the forming of rock and pop bands by teenagers as aiding the development of a new adult identity and the transition from childhood to adulthood.

The literature surrounding the idea of music being an important part of and facilitating rites of passage for this age-group, then is rich indeed. There remains, however, the question of how young people with learning disabilities may access such experiences to support their development. Riddell (2009) states that disabled young people are likely to experience social marginalisation throughout their lives, agreeing that action is needed to support inclusion. On the same topic, Rickson (2019) acknowledges that this population may struggle to develop skills that facilitate increasing independence. She believes that music therapy processes that 'take account of their individual, physical, cognitive, social and emotional strengths and challenges' (p.139) can enable the development of resources that are needed to negotiate this transition and maintain wellbeing. Key in Rickson's writing, and echoed by Riddell, is the idea that each person with learning disabilities has unique needs, making the concept of a music therapy model for this client group complex.

Using the lens of Van Gennep's rites of passage, I will posit a potential music therapy model that could support this transition for this population, taking into account the idea of liminality and its meaning in this intervention. I suggest that music therapy could be a proxy rites of passage experience for this client group. My thinking in this respect has been supported by a re-reading of Van Gennep's theories by Van Rooyen, Potgieter and Mtezuka (2006). In their paper, they discuss the importance of Initiation Schools in in the Southern Ndbele people of South Africa, advocating for their continued relevance to this society in the twenty-first century. These Schools take place in many parts of South Africa, and entail young people spending as long as 10 weeks in seclusion, taking part in secret ceremonies in preparation for their transit to adulthood. The writers further examine and explore Van Genneps' stages of the rites of passage through the lens of the Initiation Schools context, arriving at a process which unfolds in three identifiable yet fully interrelated stages, namely;

(a) severance (separation: here entering the music therapy session),
(b) thresholding (Van Gennep's liminal state, entrance, onset and acquiring new skills, beginning, dawning of a new age; here the music therapy process)
(c) incorporation (inclusion, absorption: developing interactive/social skills that may be taken back to the classroom/other settings)

To this the authors have added the idea of 'purposeful human co-existence' as the outcome of the rites of passage (p.39) in the context in

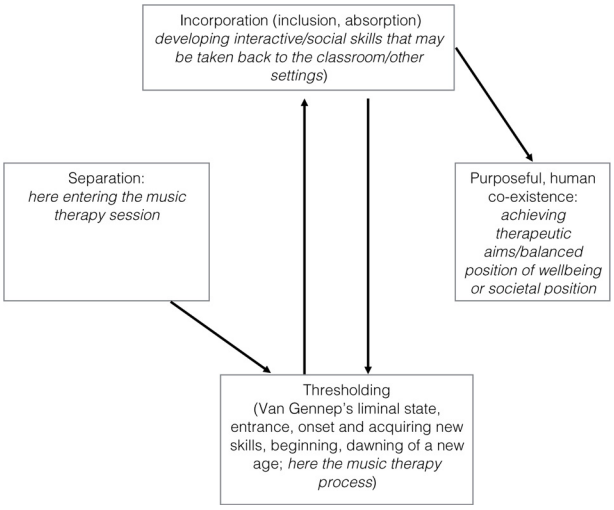

Diagram 1. Suggested music therapy rites of passage model for adolescent clients with PMLD and/or ASCs.

which they re-examined the model. This could be linked to the idea of achieving therapeutic aims, or arriving at a balanced position of well-being or societal situation.

A suggested visual representation of this model is contained in Diagram 1 with links to the music therapy process.

Liminality, rites of passage and music therapy in a specialist further education college

My own thinking about these theories arose from a piece of work undertaken in the above-mentioned setting. I was engaged to provide music therapy for a few individual students who were receiving an educational provision at the college. The students referred to the music therapy service were largely those with PMLDs as well as having ASCs. They had little expressive verbal language, and struggled to manage change and communicate their needs as well as their thoughts and feelings. The setting was therefore one with a large degree of homogeneity in the client group, something that further enabled the linking of the above theories with this work. An important part of the learning programmes at this college and others like it is preparing students for transition into life after college, be that in supported living accommodation or at home with their families. There is thus a duality of purpose in the curriculums offered; they are both educational and personal.

The setting had an understanding of some aspects of the potential of music therapy for their students; they saw it in in terms of exploring alternative ways of communicating and expressing emotion. There were, however, inherent yet unspoken tensions between the offering of an arts-based therapy within an environment where structure and strict boundaries were seen as essential to the explicit and implicit aims of the environment (Strange, Odell-Miller, & Oldfield, 2016). This was apparent in the selection of the room in which the music therapy was to take place.

Designated 'The Therapy Room', it consisted of a large, rectangular room on the first floor reached through a number of locked doors. The central part of the room was filled with a number of large heavy tables, set together as though for a meeting. There were some plastic chairs ranged around one wall, and two very large and heavy leather armchairs set at an angle to each other. Given the importance attached in much writing about the therapeutic space, most recently explored by Goditsch, Storz, and Stegemann (2017), there were issues with this room which limited the potential for therapeutic work. It was impossible to rearrange the furniture so that musical instruments could be offered to the student in a manner conducive to encouraging musical interactions. Rather, the room seemed to block the potential for this with its heavy furniture and white uncompromising walls. It was as though student and therapist were struck dumb by the space, it being difficult to find a way of working together physically as well as emotionally; there seemed no way to shift the uncompromising furniture or the prevailing atmosphere. On several occasions the key to the room was also missing, meaning we waited patiently outside the locked door until this could be located. It was clear the space was mainly used for meetings and staff interviews, its title of 'Therapy Room' merely a hangover from some previous incarnation. In order to progress work with clients, I therefore began to search for another place we could use. This search led me on a journey that took me to a physical and metaphorical space evocative of Turner's liminality and the rites of passage associated with it.

On one of my journeys around the campus attempting to find a suitable space, I was taken by a staff member to a room that was located outside the school perimeter yet within an inner and outer wall. The walls were clearly of an older construction than the new college buildings. There was a grassy area containing trees both old and newly planted. Birch and sycamore trees were growing there, with bird boxes attached to some of them; there was soft grass and wild flowers underfoot. Sunlight dappled the ground and there were a range of earthy scents filling the air. To access the space that sat 'betwixt and between' (Turner, 1967 p.93) the school and the outer world, one stepped through a wooden door in the wall, across some flagstones and into the copse. There was an immediate sense of difference, of otherness, perhaps akin to the dual process acknowledged by Turner as 'an outward visible form' and 'an inward conceptual process' (1967 p.96). Not only was the landscape different, but the room itself, a wooden cabin built in rustic style with glass walls affording views around the small wooded area was also vastly other than that we in which we had been working. Later I was able to appreciate how the very acoustic environment altered; the sounds of cars driving up to the school, voices of students and staff using the playing field and the general hum of low level sound emanating from the college main building could no longer be heard. The space felt more private, as though there was the potential to move from an outward facing state to one facing inwards. Robert Macfarlane, a social geographer, 2007) writes 'Woods have always been place of in-betweenness, somewhere one might slip from one world to another, or one time to a former' (p.98), a view that resonates with these ideas. While the concept of liminality is in fact related to the creation of what could be called ritual time, the physical space here played an important part in setting the scene for therapeutic change to occur.

As music therapy work progressed in this new space, I began to notice changes in the students I worked with that seemed to align with Turner's work. He suggests the period of liminality is an 'interstructural situation' (p.93) and goes on to write about the rites of passage being generally found in small scale stable societies. Here change occurs as a result of the shift in physical rhythms and is not related to what could be described as other innovations such as inventions or political shifts. In this setting, where change was in fact necessary due to the students being poised to leave this environment, and where it could be argued that the college itself represented a setting or institution with fixed rules and requirements, the stage seemed to be set for a potential rite of passage moment to coincide psychically and metaphorically with the discovery of this therapeutic space.

Students' body language altered as they stepped through the doorway into the wooded area; there seemed a new energy to their ways of being, a sense of agency and direction. An increased energy characterised their movements and they seemed awakened from their previous state into one in which they were more connected with the immediate environment, its sights, sounds and other sensory experiences. Once in the music therapy session, there was a clearer focus emanating from them on engaging with music and communication as well as awareness of that which was outside the therapy space. Whereas before it had been difficult for students to take initiative, here there was

a space for discovery and empowerment, a whole new world emerged in which steps towards a new way of being could be seen.

While the music therapy sessions addressed individual client need, the following composite description of a session perhaps gives a sense of the emergence of the music therapy model mentioned earlier, linking theory to practice. I have therefore used descriptions of aspects of a typical session to link to the above reading of Van Gennep's theories.

The session

(a) severance (separation: here entering the music therapy session),

David is a tall 19-year-old young man with ASC and PMLDs. He is non-verbal and does not appear to respond to his name. He lives at home with his parents but attends as a day student at the college. He has been receiving music therapy for 6 months prior to the music therapy space moving outside to the room in the woods.

I meet David in the reception where he is waiting for me with a teaching assistant. He is holding the basket of instruments. We walk across the playing fields, through the door in the wall and towards the music therapy room. I chat to David and the assistant as we walk. David doesn't respond verbally, but his stride lengthens and his normally rather lax limb posture begins to somehow become more defined and purposeful. The woods in which the room is located are empty as usual. It feels very private and yet somehow part of a bigger world to me. It's difficult to say how David perceives it.

(b) thresholding (Van Gennep's liminal state (entrance, onset and acquiring new skills, beginning, dawning of a new age; *here the music therapy process*)

On entering the room, David selects a low bean bag on which to sit in the corner of the room. His back is to the wooden beam and he faces into the room. He completely fills the bean bag, spreading his legs wide in an almost majestic way. I sit on a chair opposite very close to him. This distance has been established as necessary for him to engage.The opening 'Hello Song' is accompanied by the teaching assistant giving firm touch to David's arms and shoulders. This sensory input has been noted to assist David interacting and has become part of the ritual of the session.

Once the greeting song, accompanied by guitar is over, there is a pause. It is at this point that the dynamics shift. Earlier sessions in the previous space had focussed on more pragmatic interventions, with David being encouraged to choose from two instruments and to play. Here, David either uses eye or finger pointing to indicate the instrument of choice. While he has developed some skill in the use of various hand percussion such as guiro, agogo, small drum and guitar strumming, he often carefully watches my playing also. He continues to acquire new skills and occasionally verbalises sounds, singing on one or two occasions. He has begun to mirror any new ways of playing I offer, and I to mirror him in return. It has become difficult for me to define the moments when we each become the leader. A sense of timelessness seems to pervade the music-making. Musical dialogues arise, containing variations in tempo, dynamic and timbre. Sometimes we share an instrument, sometimes we each have the same, sometimes different. The session seems to fall into discrete sections, directed by David. Each section lasts maybe 10 minutes, with David deciding, by putting down the instrument, when it is over. Finally, David asks for the guitar and sits quietly while the 'Goodbye' song is played and sung. We then sit awhile, until David rises up from the beanbag and goes to the door.

(c) incorporation (inclusion, absorption: developing interactive/social skills in music therapy that may be taken back to the classroom/other settings)

The session contains many aspects of David developing ways of being that enable him to interact, lead and explore being with another person. Staff have begun to comment on what they noticed in the music therapy sessions with David and others. They were struck by what they perceive as a new found communicativeness and intentionality to the music-making between therapist and student in the sessions. They recognise this also post-session in the classrooms with the students. They have begun to wonder if they could also build on these changes in their interactions with the young people; they feel they are seeing students in a different light with new understandings as to their potential not just in the college but also in the outside world.

Limitations

Before moving into discussing these findings it should be noted that this work was not originally designed as a piece of research. The thinking has arisen from my own self-supervisory process and professional supervision as well as journalling, clinical note-taking and conversations with staff and a music therapy student at the college. The service users were without exception non-verbal, and therefore it was not possible to discuss the work directly with them, although there remain of course other ways in which data regarding the work could be collected to further explore this potential model of music therapy. These are discussed below.

Discussion and conclusions

Linking music therapy work with this client group at the time of their transition to adult life to the theories of Van Gennep and Turner offers an interesting way of approaching this work. At the moment, the theories do not seem to have been applied in the literature to music therapy work with this client group, although in other areas of work relating to music, they have been discussed. Aspects of musicking in music education work, such as Boyce-Tillman using the analogy of Shakespeare's' play *A Midsummer Nights' Dream,* to explore the meaning of liminality in that setting particularly resonated with the thinking behind this paper. She is interested in the transformative nature of the liminal space and uses Shakespeare's mixing of the ordinary with the magical in this play to give a sense of how this may arise. She suggests that the very 'otherness' of the wooded space, the removal from the stark reality of everyday life, gives a sense of a boundaries and safe space, yet one in which anything can happen. There is permission to play in a Winnicottian sense (Winnicott, 1971), a place where roles may be juggled and changed, where curiosity as to what may happen can be explored leading to new understandings and developments. The wood is a metaphor, as Boyce-Tillman sees it, to an entrance into another way of knowing and learning.

In the music therapy work described above, the journey to the therapy space begins the rite of passage with the separation from the ordinary. It is characterised by the stepping over a threshold, the transition into another space. The rituals, if you will, of the music therapy session described above, which could be the offering of musicking to the student, the presentation of instruments, the various aspects of the session involving joint opportunities for musical exploration may be seen as the thresholding part of the rite that is being opened up to the students. Thus Ockelford and Vorhaus (2017) suggest that music-making may be a 'proxy indicator of self-awareness and identity, particularly in those who are incapable of linguistic communication' (p.665). They further offer the idea that the metaphorical narratives that arise in sound have the potential to become narratives of self, something that may be highly relevant to this client group. Furthermore, I believe that ritual time has been created via the music therapy process. It enables the students to participate in a rite of passage leading to increased self-knowledge, or what Van Rooyen, Potgieter and Mtezuka describe as 'purposeful human co-existence' (p.24). However, perhaps without the initial work in the 'Therapy Room', where David and others became familiar with the process of music therapy, this might not have been achieved. The work of Prouty (1994) could be seen as providing an underpinning rationale for the initial work in the 'Therapy Room'. Prouty developed ideas and techniques forming part of a Rogerian model relating to making psychological contact with clients, such as those with PMLDs or dementia, for whom traditional verbal

therapy is difficult. This resonates with some of the aspects of work with the young people in this setting. The 'Therapy Room' was where David and I first met and what happened there shaped the beginnings of the therapy work. It could also be that Prouty's ideas could form part of the model show in Diagram 1 as a potential starting point for music therapy work with the client group.

In order to further develop thinking and underpin this potential model for music therapy, it would be useful to explore broadening methods of data collection from students, families, teaching and care staff. This is in development, but could include music therapy measures as well as measures commonly used by the setting's multidisciplinary team and interviews or qualitative questionnaires. Ockelford and Vorhaus (2017) suggest the use of brain imaging to identity emerging self-awareness, although no suggestion of how this might work in practice is offered. Suffice it to say, there remains scope for further exploration of evidence gathering to refine and underpin this work.

In this music therapy model, then, students can take part in something that offers them a way to begin to move into the next phase of their lives. They are liberated from the social and education-based structures in which they spend much of the day in college, and experience here in music therapy, as Turner would have it, 'an instant of pure potentiality, when everything, as it were, trembles in the balance.' (1973 p. 195). The transformative nature of this work is critical to the students ability to continue to develop and experience the next phase of life to the full. Human capacity is extended by the liminal experience that in this case is also linked to a rite of passage. Other phrases that may be used to describe this point in a persons life may be 'turning points' (Mandelbaum, 1973, p.181) or, one that when used in conjunction with this article seems most apt, 'epiphanies' (Denzin, 1989:17). These points of change are particularly important for those undergoing a period of significant change or transition, as in this case, from childhood to adulthood as posted by Nayak (2014) in his study of young males in inner cities. Furthermore, if we then apply the three stages of rites of passage as set out by Van Gennep above and further explored by Van Rooyen, Potgieter and Mtezuka, we can see that on the journey back from liminality, change has occurred and is brought into the everyday life of the traveller, in this case, the student. Of course, the music therapy is not a one-off event but a weekly occurrence, giving the chance for these three phases to be worked though and experienced week by week, potentially building on each session and experience, giving the work time to embed in the students way of being.

While applying the above mentioned theories to this client group in music therapy appears to be unexplored, it should be noted that there is also a lack of literature at present examining transition to adult life for young people with PMLDs and ASCs. Pickard (2019) has written compellingly about individual music therapy with this client group using a humanistic paradigm. She suggests that the Rogerian approach is inherently inclusive, and challenges existing paradigms of the social-model of disability. She further emphasises the importance of moving away from an accepted deficit-based paradigm and 'shifting the gaze towards societal structures' (Woods, 2017, p.1094). This would seem to resonate with the emerging model proposed in this paper. However, one wonders why there is such little literature other than case study exploring theoretical paradigms with these clients when in fact music therapists carry out a considerable amount of clinical work with this population.

Utilising the theories of Van Gennep and Turner has proved invaluable for my practice in developing music therapy with this client group. It is an ongoing piece of work in which a focus is given to the work supporting the students as they transition to adulthood. It puts them on a footing with other young people of their age, acting as a way of thinking inclusively about the client group. Music therapists commonly work with clients with these needs at this time of their lives, so it would seem important to further consider the potential value of developing this and other approaches to our work. Relevant and considered theoretical underpinnings to support client need have the potential to develop an evidence base, and I believe that these theories have the potential to offer another perspective to our profession when working with this client group.

Acknowledgements

I would like to acknowledge the work of Nick Wilsdon (d. 2017). His Masters dissertation in Music Therapy at the University of South Wales in which he discussed the theories of Turner in relation to rituals in music therapy inspired my further exploration of liminality and rites of passage in my practice.

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Riding in Tandem: Journeying the Research-Teaching Nexus in Partnership.

Elizabeth Coombes and Beth Pickard.

Online Conference for Music Therapy, February 2020.

University of South Wales Prifysgol De Cymru

(Liz) Welcome to our presentation today. I'm Elizabeth Coombes, course leader of the MA Music Therapy at the USW…

(Beth) and my name is Beth Pickard and I am a Senior Lecturer on the programme.

(Liz) We are going to give a joint talk today in which we will give a perspective of music therapy training from the UK and Wales in particular. We hope this will enable you to think globally about music therapy and relate our experiences as therapists and educators to your professional practice. We will be discussing the importance of researchful practice and self-supervision, as well as exploring ideas relating to music therapy students' learning processes.

Introduction

- Context: The MA Music Therapy at the University of South Wales and the HCPC Standards of Proficiency in the UK.

- Introduction to the Research-Teaching Nexus (Healey, 2005).
- A New Model – The Practice-Teaching Nexus (Coombes, 2019).
- Tandem Supervision Model (Milne and James, 2005).

- Case Study 1: Learning About Research Through Conducting Research, Beth Pickard.
- Case Study 2: Developing Reflective Practice Using Music Listening and Art-Making , Elizabeth Coombes.

- Discussion.
- Conclusion.

(Beth): Today we're going to talk about some recent innovations to the MA Music Therapy at the University of South Wales, the only Welsh Music Therapy programme here in the UK. We will position this alongside the Health and Care Professions Council, or HCPC's (2013), Standards of Proficiencies, which UK Music Therapists must evidence, and to which UK training courses must map their curricula.

We will then provide some theoretical context to our presentation by presenting Mick Healey's (2005) Research-Teaching Nexus, which has been a valuable framework in both of our pedagogical practices; enabling us to critically reflect upon the intentions of the curriculum, and the role we aspire to enable students to take in their learning, research and practice. Liz will then present an innovative adaptation of this framework (Coombes, 2019), devised as part of her ongoing PhD research. We will also briefly mention Milne and James' (2005) Tandem Supervision Model, which also features in the title of our presentation.

We will then proceed to sharing two case studies which demonstrate how we have each been exploring the research-teaching nexus in partnership with our music therapy students at the University of South Wales this year.

The presentation will conclude after some discussion emerging from both case studies, and consider some potential recommendations for future practice.

Context: MA Music Therapy at USW

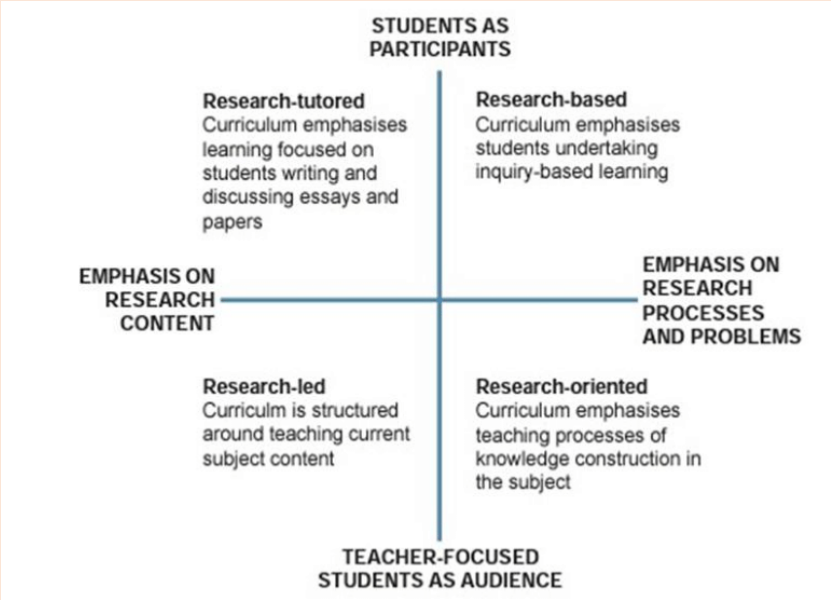
- Currently 3 year, part time Masters programme at USW Newport City Campus.
- Only MA Music Therapy course in Wales.
- Interprofessional learning occurs with the MA Art Psychotherapy and other courses in the subject area.
- Placements a vital part of learning.
- Strong emphasis on students as **participants** rather than as **audience.**

hcpc registered www.hcpc-uk.org

University of South Wales Prifysgol De Cymru

(Liz): The MA Music Therapy training course is currently a 3-year part-time Masters qualification. The part-time option makes the course accessible to those who will need to work alongside their studies, broadening the diversity of trainee practitioners in the profession. Interprofessional learning occurs with the MA Art Psychotherapy student group, as well as seminars being delivered by other healthcare and professionals from other areas of work such as education. Placements are at the core of the course-work as for all clinical trainings. Of high importance for the course and university in general is the idea of students being participants and not members of an audience receiving our teaching.

The Research-Teaching Nexus (Healey, 2005)



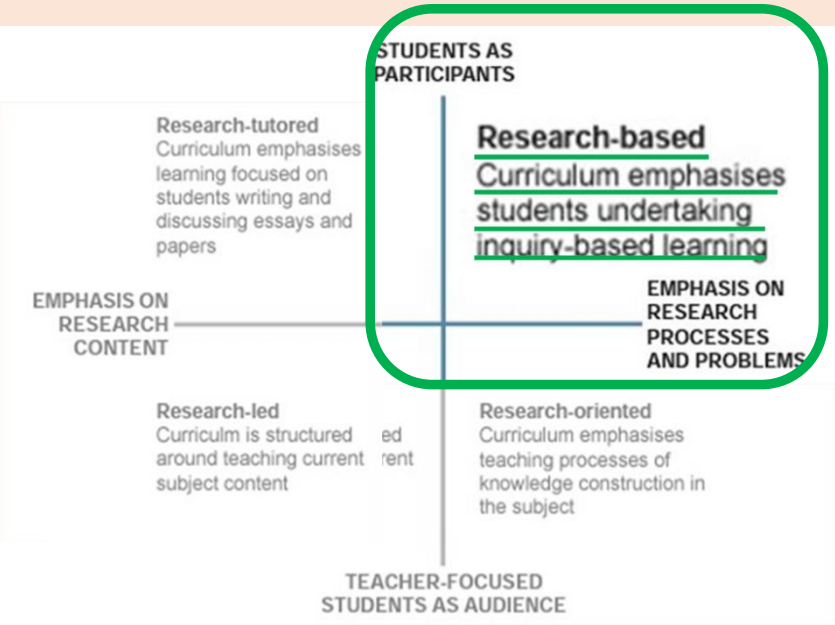
(Beth): As noted in the introduction, Healey's (2005) Research-Teaching Nexus has been a valuable lens for both Liz and I in critically reflecting upon our pedagogical choices, and in developing a curriculum which promotes active learning and meaningful participation for our students.

Healey's (2005) original model, presented in this diagram, proposes four quadrants of pedagogical approach, situated between four poles. On the vertical axis we see a continuum between "students as *participants*" [italics added], and "teacher-focused, students as *audience*". This felt like a relevant dimension to explore, in light of the aforementioned fact that our course welcomes a number of 'non-traditional' Masters students, in line with the university's widening access and participation agenda (USW, No Date). By this we mean that some of our students might not have experience in research methods prior to engaging with our course, and some students may have entered via the 'accreditation of prior learning' (APL) route, and so will have demonstrated the entry criteria via professional experience as opposed to via an undergraduate degree. As such, there is often much content about research methods that is valuable to share with students, but if this is delivered via a didactic, transmission model (or in this case, the "students as *audience*" model), this can result in a passive learning experience and over-reliance on the lecturer (Machemer and Crawford, 2007). This also devalues the richness

of students' prior learning and experiences. The "students as *participants*" pole advocates active learning whereby students develop their knowledge and skills through embodied learning and by applying their evolving knowledge in practice. There is evidence to suggest that students learn more when actively involved in constructing their knowledge in this way (Barkley, 2010; Smith and Cardaciotto, 2011; Daouk, Bahous and Bacha, 2016).

On the horizontal axis of this model we see a continuum between an "emphasis on research *content*" and an emphasis on "research *processes and problems*". Again this feels particularly relevant to students who may have little experience of research methods, and thus the temptation might be to focus on research content, such as providing lectures about various methodologies. However, by engaging students in a research *process* there is scope for active and meaningful learning about the lived experience of these challenges and opportunities, in a safe environment.

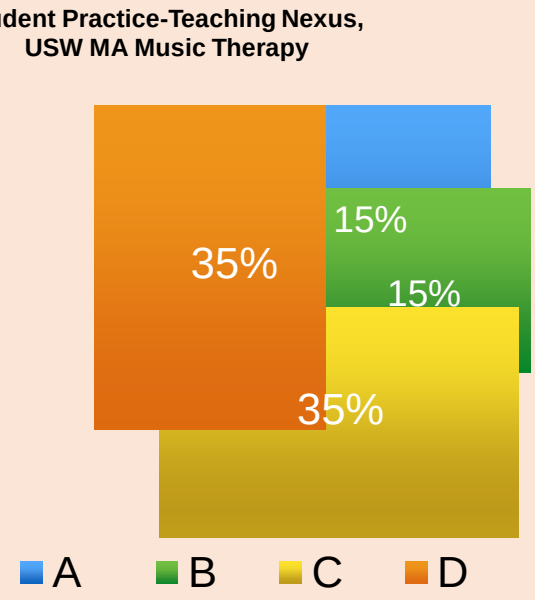
The Research-Teaching Nexus (Healey, 2005), cont.



(Beth): As such, both of the case studies presented largely focus on the top-right quadrant, which Healey (2005) defines as a "curriculum emphasising students undertaking inquiry-based learning". On the MA Music Therapy at the University of South Wales we value "students as *participants*" rather than "students as *audience*", and seek to surface learning through a focus on *process* over *content*.

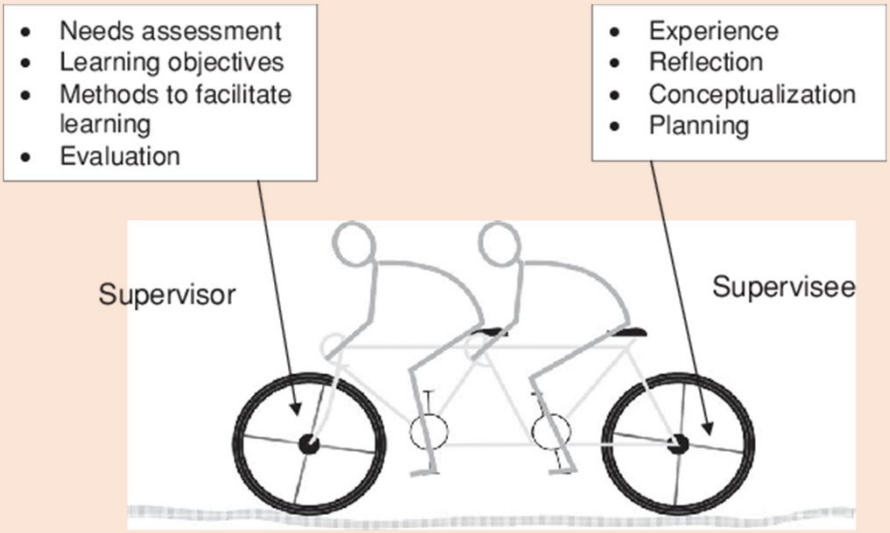
Proposed Practice-Teaching Nexus at USW
(Coombes, 2019)

Legend	
A	Research and Practice Tutored Curriculum emphasises learning focussed on students writing and discussing papers
B	Research/Practice Led Curriculum structured around teaching subject
C	Research and Practice based Curriculum emphasises students undertaking inquiry-based learning
D	Research and Practice Oriented Curriculum emphasises teaching processes of knowledge construction in the subject



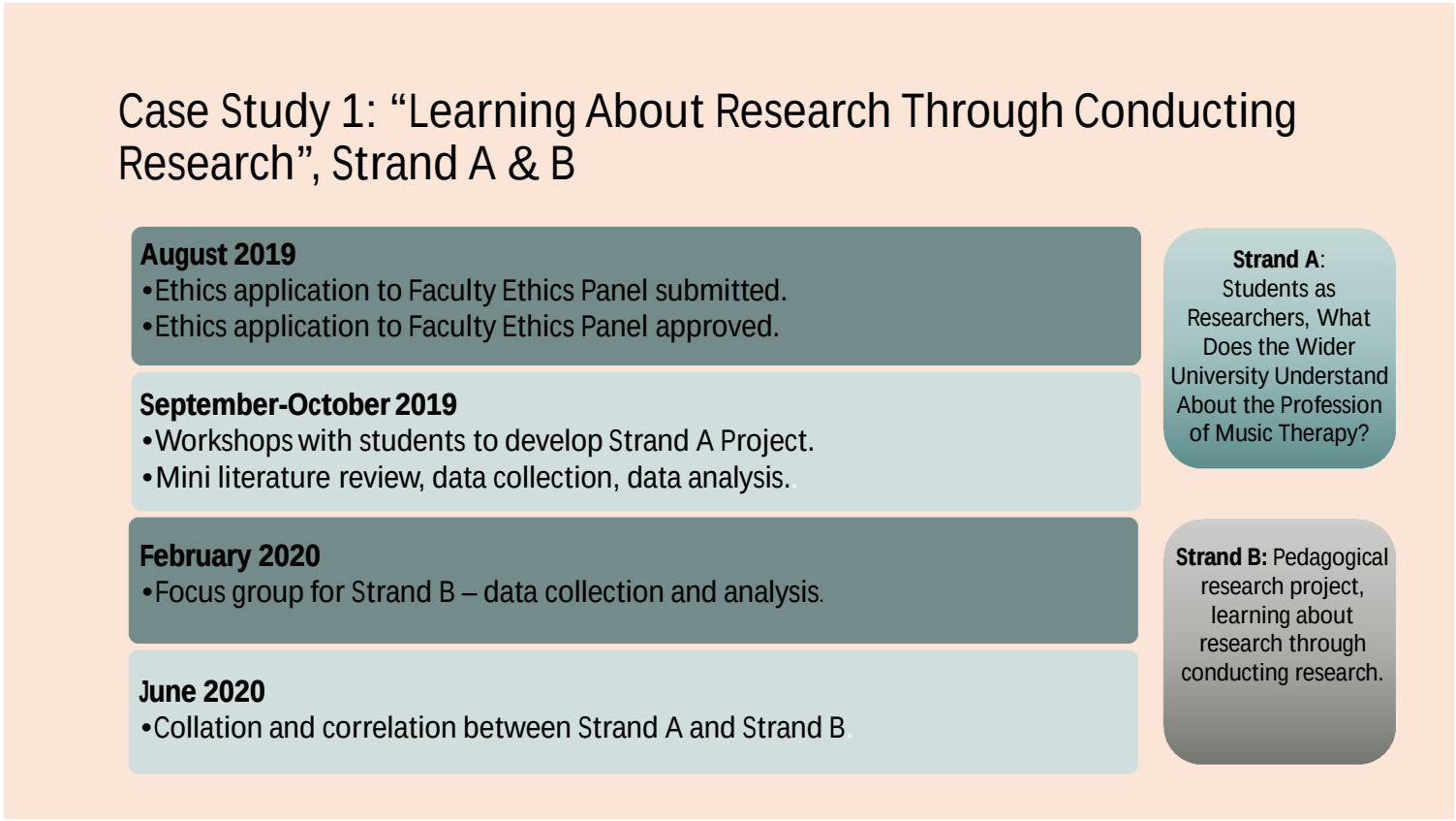
(Liz): Healey's nexus focusses on the research/practice debate within teaching. My current PhD studies focus on the idea of an emerging twenty first century music therapist identity- what does that look like? It's important that as music therapists we can work with a wide variety of client groups and have a broad knowledge base, but we can't know everything. How can we develop tools to ensure that students become practitioners who can go out into world and know how to find out what they need to know to work effectively? My proposed model of teaching then offers a suggested breakdown of teaching areas. It uses inquiry based learning and processes of knowledge construction as the larger parts of the curriculum - 70% in total, with more formal learning techniques such as discussing existing literature and teaching music-centred techniques showing as 30% of the total. The model itself is a work in progress, but it gives a flavour of the importance of the students developing their learning collaboratively and in action rather than being more desk-bound receivers of 'wisdom' so to speak, delivered by lecturers.

Tandem Supervision Model (Milne and James, 2005)



Cycle path of learning and development

(Liz): Although this model relates to the supervisor process, this image is one I found useful when considering how I as an educator work with students. My own reflective practice as a therapist and teacher for 20 years have shown me that there are strong motivational aspects to my practice in these areas. I contend that there are occasions when I am able to be the 'back-seat' tandem rider in a sense, where I act as the motivator or 'dynamo' if the bike were to have such a mechanism, driving the supervisee or student here on the path that is needed to reach their learning goals. The following two case studies provide examples of our learning and teaching approach on this MA Music Therapy course.



(Beth): The first case study includes two strands of activity, referred to here as Strand A and Strand B. Strand A, is a live research project, where students are enabled to embody the role of active researchers in order to develop their understanding of research methods through lived experience of the process.
Strand B is a pedagogical research project, where I am seeking to explore the students' experience of Strand A.

An ethics application was submitted to the Faculty Ethics Panel in the Summer of 2019, and the application was approved for both studies to commence in September 2019. As such, an intensive, immersive project was embedded within the first month of the students' third year module. This was an innovative shift from previous years, where a focus on content has offered some traditional, didactic teaching at the outset of the module to provide students with the necessary skills to embark upon a research project. This year, students would learn about research *process* by embodying the role of co-researchers.

Strand B will commence next month, in the form of a brief Focus Group with the students, who will have submitted their own individual research proposals at this stage. I will be eager to understand the students' experiences of the immersive, live research project, and to explore

whether they felt this was a valuable learning experience to inform their individual projects.

Case Study 1: A Focus on Strand A

"What is the wider university community's understanding of music therapy?"

- 4 weeks of practical workshops exploring research practice:
  - **Ethics** and **literature review.**
  - **Mixed methods questionnaire.**
  - **Data Collection:** 39 respondents participated.
  - **Results presented in an academic poster** for the biannual British Association of Music Therapy (BAMT) Conference 2020 and the USW Student Conference 2020.
- Learning from this experiential project informed the subsequent development of students' individual, assessed research proposals (in process).

(Beth): As noted, for the first time this year, students spent the first month of this module conducting a live, collaborative research project. The research question was "What is the wider university community's understanding of music therapy?"

In the first week of the module we explored the approved ethics application together and developed a mini-literature review to inform our research study. Each student searched for and reviewed one article which would contribute to our collective understanding, and we discussed as a group how the literature might inform our next steps. This was an applied introduction to critical engagement with literature.

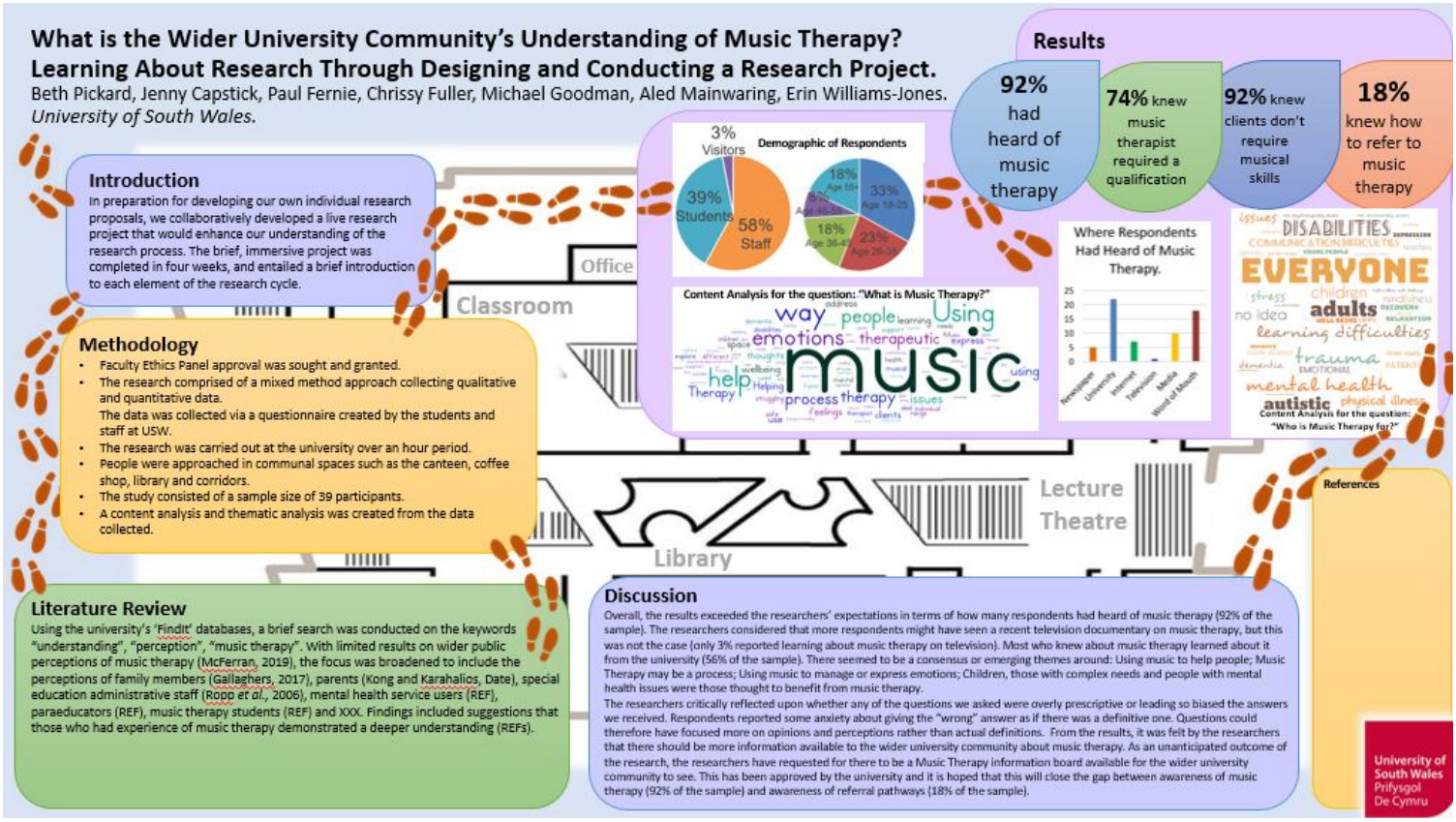
In the second week, we collaboratively devised a mixed-methods questionnaire which would enable us to collect data which would seek to answer our research question. Through discussion, practical activities and piloting with peers, the rationale for the chosen questions was critically explored.

In the third week, the questionnaire was administered on campus during a busy lunch hour. Every member of the team engaged with the university community to introduce the research in an ethical way, and collected data. Between the seven members of the team, we collected thirty-nine

responses in an hour.

In the fourth and final week, the results were collated and analysed, and tentative conclusions were drawn. We considered the different possible cross-sections of data we could pull out, and had to decide which elements of the project we wanted to prioritise in our write up. Critical discussion enabled students to also consider some of the strengths and limitations of the methodological decisions made in previous weeks, and to consider recommendations for future iterations of such a study which might offer more relevant or robust results.

At the conclusion of this immersive project, students were invited to commence their planning of their own individual research proposal, informed by the experience of completing an entire research cycle through this immersive, live research project.



(Beth): This slide includes a *draft* version of our collaborative poster, reporting on this research study. The poster outlines our research question and the intention of our studies, and is formatted around a hypothetical blueprint of the university campus where the research was situated. Footprints guide the reader around the campus and around the write up of our experiences. Our literature review showed us that understanding of the profession was significantly impacted by witnessing or observing a session. This guided the development of our questions to an extent, as well as recent and well received documentary about music therapy on British television.

The methodology comprised a mixed methods questionnaire, delivered to 39 participants during the one hour data collection period. You will note interesting findings, including quite a high awareness of the profession (at 92% of the sample), and much of this awareness coming from the university (56% of the sample). We were surprised that only one participant had heard of music therapy on television, and so the documentary that we were quite aware of was not as impactful or widely known as we had anticipated. When asked what music therapy was, a content analysis shows the prominent answers, which largely centred around "using music" in a "therapeutic" way to explore "emotions", "feelings" and "expression". When asked who music therapy might be

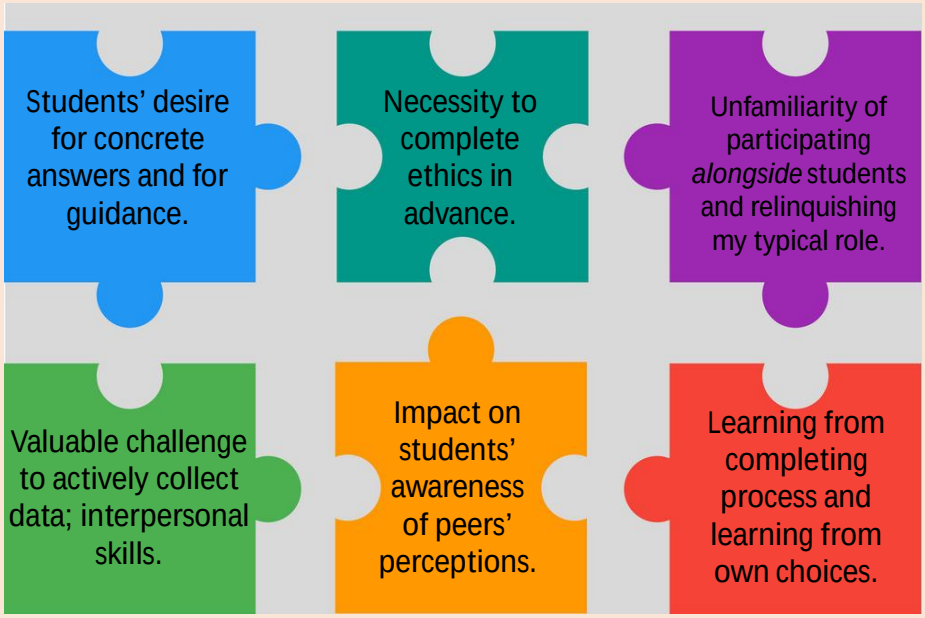
beneficial for, some respondents gave very open answers, including “everyone”, “adults”, “children” and “all ages”, whereas others focused on specific client groups such as “mental health” and “disability”. The word “trauma” was mentioned several times which was insightful.

The sample was 58% staff, 39% students and 3% visitors, and there were respondents in all the noted age groups. The highest proportion of respondents were in the 18-25 age group, but the remainder were relatively evenly spaced across other age groups.

The most significant finding for the group was that although 92% of the sample had hear of music therapy, only 18% knew how to refer into music therapy. This felt like an important gap in knowledge and awareness and was a key learning point from the study.

During the project, the students further explored how to respond to a call for contributions and were subsequently successful in their submission of an abstract about this research project to the prestigious biannual British Association of Music Therapy Conference in April 2020. As such, we are in the process of refining our poster and the students will present it to the UK Music Therapy community, securing their first publication before they graduate. We feel this is an exciting outcome of this pedagogical research project, which is not only levelling the playing field as students enter into researchful practice, but is offering an accelerated opportunity for publication and engaging with the professional research community.

Case Study 1: Discussion of Strand A.



(Beth): There were a number of unanticipated findings from this research project. These included a realisation of the students' desire for concrete answers and guidance from their tutors. This may reflect their experience of teaching to date, or their uncertainty in exploring this potentially new aspect of their training.

A real barrier to the authenticity of this project was the necessity to complete an ethics application in advance of the project beginning. As such, some elements of the project (including the research question) had to be pre-determined, and this arguably limited the students' autonomy to develop the fundamental focus of the research, as well as the central ethical considerations.

Upon reflection, I found it challenging to embody the role of co-researcher and felt an urge to return to my more familiar role of facilitating learning through sharing information. Many times, I felt myself eager to introduce information that may change the trajectory of the students' process, but I remained aware that the intention was for them to be enabled to learn from their own choices and to experience the impact of their methodological decisions; within the boundaries of a safe, ethical frame. This gave me much to consider in understanding my role as an educator and my tendencies in different learning situations.

An unanticipated benefit of the project was to challenge and enable students to interact with members of the wider university community. Some students found this daunting, but rose to the challenge of articulating their research and discipline in a professional way. Several students have reported that this was significant in both their personal and professional development.

A further unanticipated outcome is that the research highlighted to students that their discipline was not as visible within the university community as they had perhaps anticipated. As such, the students subsequently requested a notice board on campus where they can share about the profession of music therapy, and continue to educate and inform the wider university community about what we do.

The final discussion point is yet to be measured, but it is hoped that completing the entire research cycle, including analysis and reporting, will enable students to critically reflect upon methodological choices, and as such will enable them to construct an increasingly robust research proposal for their own assessed submission; benefitting from the holistic and applied knowledge gleaned from this collaborative venture.

Case Study 1: A Focus on Strand B

- Pedagogical research project to explore students' experiences of participating in a live research project.
- Project is ongoing; Focus Group is planned for early March 2020.
- Aims to address a gap in the research exploring ***pedagogy of music therapy***, specifically (Edwards, 2013; Goodman, 2015; Edwards, 2016; Fansler *et al.,* 2019).

- Enabling students from less academic backgrounds to participate equitably in music therapy research and practice; **diversification of the profession**.

(Beth): The second strand of this research project will be completed in early March 2020, when the students will have submitted their individual, assessed research proposals and will be invited to a Focus Group to reflect upon the experience of participating in this project.

Regardless of the outcomes, it is hoped that this project contributes to the small but evolving body of research about music therapy pedagogy (Goodman, 2015; Edwards, 2016; Fansler *et al.,* 2019). As Jane Edwards (2013, cited in Edwards, 2016, p.847) notes: "at a wider systemic level the values and processes of training are influenced by the provider institution", and it is hoped that this model may go some way to levelling the knowledge and experience of 'non-traditional' students entering the profession, enabling those from less academic backgrounds to contribute to the researchful and evidence-based priorities of our profession. Widening access to and participation in Higher Education is an important value of our institution (USW, No Date), and Liz and I are committed to widening equitable access to the profession of music therapy, with an awareness of the lack of diversity in the current profession: across training, workforce and potentially client populations due to potential limiting dominant discourses (Hadley, 2013; Baines *et al.,* 2019; Fansler *et al.,* 2019).

Case Study 1: Concluding Thoughts.

- Learning ‘in action’ about the challenges of research methods in our field.
- Different pedagogical experience for educator.
- Time away from assessed task.
- A more of a level playing field after each participating in a live research project before commencing their own assessed project.

(Beth): In conclusion, this project provided an active and applied learning experience of research methods to the students, and a different pedagogical experience to the educator too. This promotes critical reflection on both parties roles in the context of Higher Education.

A prominent difference at the time of delivering the module was that this was four weeks where students *weren’t* explicitly focusing on their own assessed task. It will be understood when the assignments are submitted whether this time was valuable in enabling a deeper, more holistic understanding of the research cycle, or whether this was detrimental to the rigour and depth of the final assessed submissions.

It is hoped that the project has enabled each student to commence their assessed task with lived experience of research, promoting a more equitable starting point.

Case Study 2:
Developing Reflective Practice Using Music and Imagery

- Reflective Practice - important for all therapists and practitioners.
- Professional guidelines in the UK and US as well as other countries highlight importance of reflecting on practice:
  - https://www.hcpc-uk.org/standards/standards-of-proficiency/arts-therapists/
  - https://www.musictherapy.org/about/standards/

- How do we reflect?

- Importance of encouraging students to develop own ways of reflecting.

(Liz): Increasingly healthcare professionals are required to utilise reflective practice both within their initial training and continuing professional development. It is also seen as a Higher Education (HE) transferable skill in the UK and part of the MA Music Therapy training at USW as well as a requirement for successful completion of the HCPC Standards of Proficiencies. Evidence of reflective practice skills are required by the Quality Assurance Agency (QAA) which also regulates and oversees HE provision in the UK. It is clear, then, that any music therapy course should in fact support the development of this skill in student

How to reflect?

- Multiple ways including:

✳ **Writing;**

✳ **Improvising;**

✳ **Making;**

✳ **Using Music and Imagery as a means of reflective practice.**

(Liz): There is much written on the topic of teaching reflective practice and how students working in applied and social sciences develop this skill in the UK. Likewise, there exists a body of literature about the theory-practice gap, whereby students are taught theory in educational seminars, but find that in the real world of practice, they are required to use different skills (Salvage 1998). Benner (1984) found that while novice practitioners rely on theory based rules to direct their decision making, experts draw largely on intuition based on their past experiences. This would seem to indicate that developing reflective practice skills is of importance to clinicians in a wide variety of fields.

Although these last two references are located in nursing literature, they ring true when one considers matters raised in Odell-Miller and Richards (2009) book on supervision in music therapy. In this text, there is much discussion on the topic of reflection on clinical practice for students of music therapy, and how learning and development of reflective practice and the therapeutic persona occurs. The text also discusses Kolb's experiential learning cycle (1984), acknowledging that reflection follows experience, leading to sense making of experience. This then supports the development of future work. Although there exist many music therapy texts commonly used by universities in the teaching of students of the profession such as Pavlicevic (1999), Bunt and Hoskyns (2002) and Bunt

and Stige (2014) to name but a few, there is no writing that specifically describes pedagogy in relation to the teaching of reflective practice on music therapy trainings. There are some texts demonstrating reflective writing in this field of practice, such as Pavlicevic (1999) and Molyneux (ed. 2018). At USW in the first year of the course we expose students to the models and thinking mentioned above, and, as a reflective log is part of the assessment in year 1, we suggest there may be multiple ways of reflecting on clinical work and the learning experience. It would seem, therefore that there exists an area of pedagogical practice that could be developed in the profession.

Developing Reflective Practice Using Music and Imagery

- Can select a focus to aid reflection.
- Can use supportive music according to needs of students.
- Potential to widen discourse.
- Offer a new way of reflecting in supervision and potentially in a peer group or alone.

(Liz): Although there is much written about Bonny Method Guided Imagery in Music (BMGIM) and Group Music and Imagery (GMI), (Grocke and Moe 2014) there is no mention of the possibility that this method could be applied in music therapy reflective practice pedagogy nor is there any mention of the potential use of GIM for music therapy students other than those undertaking the GIM training.

I found no specific mention of Group MI as an aid to developing reflective practice skills in any writings on music therapy training. Despite some GIM teaching being offered on trainings in the UK at UWE, Queen Margaret University and also in trainings in other parts of the world such as Denmark, it would appear that no writings have been published on the benefits or use of this method for music therapy students, although some GIM practitioners, notably Beck (2012) and Trondalen (2014) have interrogated the use of GIM as a resource for musicians and music skills

I began to wonder if my thoughts about using MI as an aid to reflective practice could be of use, and with this in mind developed the pilot study.

Case Study 2: Developing Reflective Practice Using Music and Imagery

August - September 2019
- Ethics application to Faculty Ethics Panel submitted.
- Ethics application to Faculty Ethics Panel approved.

December 2019
- Reflective Practice Seminar Delivered.

January 2020
- Questionnaire relating to student experience of the intervention completed and analysed.

(Liz): For this enquiry, a qualitative research perspective was selected as the aim was to elicit informal student feedback as to whether they felt the methods used assisted them in their development and learning. In addition, my own thoughts and reflections gleaned from supervision and reflective journaling formed part of the data for this project. This work then fell within an interpretivist or post-positivist epistomological paradigm. The study would gain some understanding of the experiences of the students, a particular phenomenon, rather than generalise its research.

Data Collection

Once ethical clearance had been obtained, the students were recruited into the study. Final year students were selected for this piece of research. They agreed for the artwork to be used anonymously to contribute to the project, and for their feedback comments to be used to provide a commentary on the experiences. Feedback was obtained verbally at the time and later in a questionnaire. It may be that further feedback arises in the end of academic year evaluations.

Case Study 2: Intervention

- 6 students took part in a supervision seminar lasting 1.5 hours.

- The format of the intervention was as follows:

  - Short piece of music listening to open the session and ground group.
  - Focus of sea and all that might be within and around it given to students with suggestion to focus on a client, group or setting.
  - *Swan of Tuonela* by Sibelius played while students create images with pastels and other drawing materials.
  - Post image-making, students share and discuss images within the group.
  - Short piece of music listening to close group and 'land' safely.

(Liz): Six Final year MA Music Therapy students took part in the supervision seminar that took place in the last week before the Christmas break. The seminar was 1.5 hours in length. The gender split was 50/50 female/male. The sample was dictated by the seminar in which the work took place.

The seminar focussed on interrogating a therapeutic relationship with one client as they began to develop a stronger therapeutic persona. As two students had not commenced clinical work they were invited to focus on the setting in which they were to practice.

A listening experience opened the seminar. This was in order to clear their minds of the trappings of their journeys to the university that day, and feel a clearer space for reflection. I used the flute and harp 'Sicilienne' from the 'Small Containers' set of pieces compiled by Swedish Psychiatrist and GIM practitioner Dag Korlin. Using this piece with its airy sense of movement felt as though it had potential to offer a clarifying experience.

A variety of art materials were provided for all, with the piece of music to which students would image being 'Swan of Tuonela' by Sibelius. I felt its rich potential for imagery and sense of a journey could be of use.

Grocke (p.104 2002) also describes the timbre of the cor anglais offering the idea of a 'voice of admonition, an authority figure, either suggesting to the client they "should" do something, or alternatively giving the client freedom'. The ambiguity and tension contained within the music offers options for exploration, somewhat appropriate to the advanced level of the students' training where they must make complex clinical decisions themselves. I gave a strong focus to begin with, that of the sea and all that could be found in it; sea creatures, rocks, seaweed, etc. This was used to assist the students in having an imagery focus to guide them as a support to begin drawing.

Each student then had the chance to discuss their work with group as a whole reflecting on the experience. I took notes throughout.

The session ended with a short listening experience using the piece 'Wilma' by Swedish composer Stefan Nilsson. This was to seal and contain the experience.

Case Study 2: Data Collection

- I took notes of discussion during the session.
- In the supervision session, students shared openly and with curiosity about their own and others images.
- 6 weeks later a questionnaire was completed by students about the experience and any impact on their reflecting/work.

(Liz): Data collection occurred in a variety of ways.

The images created themselves were part of the data with my notes of the discussion that occurred during supervisions forming another part. 6 weeks after the intervention, questionnaires were completed by students describing their experiences of the intervention.

The following two slides contain images created in the seminar.

Student Example 1: [The Bubble]

- Setting.
- Imagery.
- Feelings.
- Group feedback.

(Liz): The following two slides contain images created in the seminar.

This image was created by a student who had not yet commenced clinical work in the setting due to a variety of reasons. There is sun at the top which is trying to shine through all the different layers of the placement. This could be music therapy. The bubble he recognised as himself. This is an image that occurred in the second year of training when representing himself. Is the darkness at the bottom of the picture his own material or that of the clients? What are the links? Is he chained to his own material? Is he trying to escape it? One student commented that it looked like an anchor keeping him secure.

Student Example 2: [Rocks and Sand]

- Setting.
- Imagery.
- Feelings.
- Group feedback.

(Liz): This image was created by a student working with groups of clients in a substance rehabilitation programme. She had recently had a very difficult group session with one client being verbally attacking towards her and this had provided many challenges for her. She had, however, been supported by the client group the following week when she brought this experience to them as part of the therapeutic work. Initially she thought she was the rocks and the group the sand. On reflection she felt the group was the rocks with herself and the client sparring in the middle. There was a combative element to the drawing. We were drawn into a discussion of the therapeutic persona and how this enables the therapist to work in a way that is quite different from how one would face such challenges in one's private life. I felt as though we in fact did not have enough time to look at all the different layers of meaning within this image. The student has since further reflected on the image personally in therapy and also in clinical supervision on placement.

Case Study 2: Results

- Students found the Music and Imagery reflection useful.
- Wanted more of this method - new insights generated.
- Sharing thoughts.
- Common themes.
- Supporting each other.

(Liz): Firstly, all students demonstrated a high level of engagement with this work through participation and group discussion. All felt the images were food for further reflection. My own thoughts were that the group were highly engaged. The work enabled them to fully focus on the experience that was being discussed and not become side-tracked by their own experiences of their work. Having an object presented to them by a peer as part of the supervisory process seemed to help.

The qualitative data gathered which took the form of informal discussions during the seminar and questionnaire data showed students highly valued this type of supervision. The reflections that occurred during the seminar were insightful and showed students had a high degree of insight into their peers' work.
Questionnaire data included such comments as one student stated 'it made the clinical environment come alive on the page'. Others valued the silences that occurred as part of the process, and the 'time to create'. One person said 'it helped me to observe my clinical work in a way that felt separate'. All valued the experience, stating it had impacted their clinical work, and wanted more; the only aspect that students felt would have improved the experience was a longer session so the had more time to create and reflect.

My own reflections indicated that students were able to think more deeply about connections and comment on their own at the work of others. Additionally I felt that working with the students in this way gave me more insight into their reflective processes and ways of approaching clinical work. This was of use when supervising their work and working with them on areas of personal learning.

(Liz): It was clear from all the data collected that this intervention was highly valued by the students. The comments they made indicated that for this group it was indeed a valuable exercise that prompted different insights into work and their own processes. The intervention had been used previously with other student groups who had given positive feedback, but this was the first time that it had formed part of a formal research project. There was already, then existing anecdotal evidence suggesting that students valued the method and wanted more of it.

The qualitative data gleaned from the intervention showed that there was perceived value for the students in including Group MI as part of their learning. As course leader, I also felt there was value in the intervention, although ascertaining whether it had in fact assisted students in reaching learning outcomes was difficult to ascertain due to the self-reported and limited nature of the data obtained. The intervention did, enable students to develop their reflective capacity and to work with the unconscious, something which is an intrinsic part of this psychodynamically orientated training.

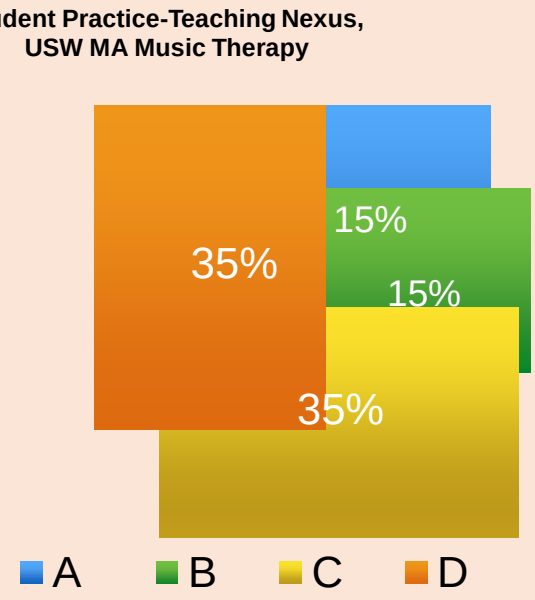
Another iteration of the method could involve utilising a questionnaire from which some quantitative data could be gleaned. This would provide additional information that could have suggest what elements of the

intervention in particular the students feel are helpful, and whether in fact these techniques were in any way adapted and adopted into their reflective work. If this method is to become embedded in the course supervision groups, other staff members would need to be trained in the delivery of the intervention to ensure there is parity between what is offered to the student cohort.

From a research point of view, the small study has shown that this method of supervision is appropriate and will be utilised on the MA Music Therapy training at USW in the future.

Proposed Practice-Teaching Nexus at USW (Coombes, 2019)

Legend	
A	Research and Practice Tutored Curriculum emphasises learning focussed on students writing and discussing papers
B	Research/Practice Led Curriculum structured around teaching subject
C	Research and Practice based Curriculum emphasises students undertaking inquiry-based learning
D	Research and Practice Oriented Curriculum emphasises teaching processes of knowledge construction in the subject



(Liz): If we now return briefly to the proposed Practice/Teaching Nexus, we can see that the first piece of research undertaken by Beth potentially sits within area C of the of chart, while the reflective practice project sits within D. Using this diagram as a tool to begin to identity pedagogic methods appropriate to music therapy trainings could provide lecturers opportunity to enquire more deeply into the way their students acquire and build on knowledge and skills in their training and once qualified.

Conclusions

- Evaluating impact to determine legacy.
- Developed research capacity of staff and students.
- Introduced a new reflective tool - for group or alone.
- Demonstrated value of exploring new ways of reflecting.
- Group was very supportive of each other.
- Showed benefits of students as **participants** versus **audience**.

(Beth) The process of evaluating the impact of both projects is ongoing, and will arguably be further determined as this cohort graduate and commence their professional careers. We are eager to understand the potential legacy of these ideas, both for the students as clinicians and for the course curriculum.

A benefit of both projects is that they have enriched the research capacity of both staff and students. Students secured their first publication through Case Study A, prior to graduating from the course. Some students appear to have been motivated by this and are pursuing and securing further publications. As members of staff, we are both pursuing a PhD by Portfolio and conducting active research enables our pedagogy to remain contemporary and evidence-based.

(Liz) As Beth says, we will further evaluate the impact of each project at the end of the academic year and potentially beyond. Due to student demand, I will be undertaking another such reflective practice session with the final year music therapy students before they end their studies. It will be interesting to see if they have personally employed this technique in the meantime as part of their own reflective practice. Perhaps this method could become a recommended form of reflection for music therapy students and therapists as we continue to develop our

profession.

(Beth) Overall, we hope both projects have illustrated our commitments to empowering students as active participants in their learning journey, rather than passive recipients (Healey, 2005; Coombes, 2019). We endeavour to continue our learning in this field and to continue to inform the course curriculum with our findings.

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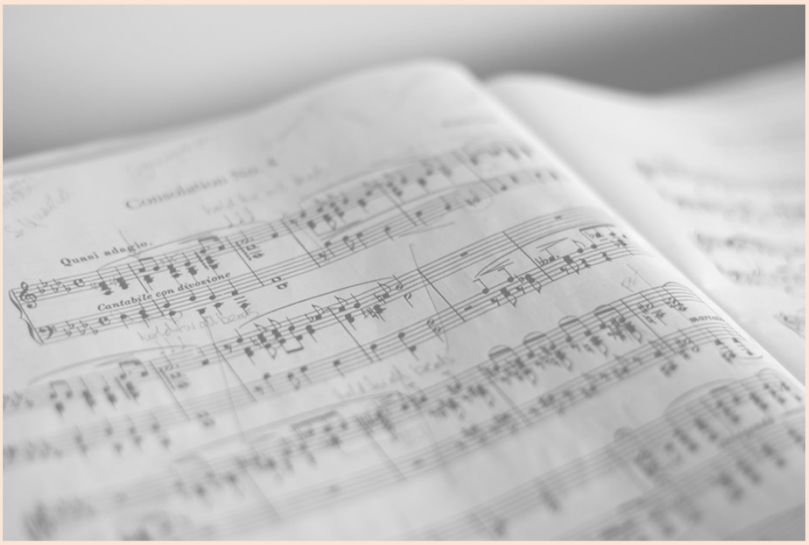
...and a few more references...

Thank you / *Diolch yn fawr.*



Thank you for attending our presentation, we would welcome any questions or reflections.

Voices
A WORLD FORUM FOR MUSIC THERAPY

Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank

By Elizabeth Coombes

Introduction

In the ever-widening music therapy community, more and more opportunities are arising for Western trained music therapists to work in multi-cultural contexts within their own country. Additionally, there are increased possibilities for music therapists to work in countries other than their own native homelands. These opportunities, however, come with added considerations and responsibilities.

Traditionally, music therapy practice has insulated itself from the cultural context in which the work takes place. Mércèdes Pavlicevic (2004, p. 37) describes this when she remarks that, “Inside the existing and received canon of music therapy theory and techniques, a culturally neutral stance has preserved a comfortable seal between ‘inside’ and ‘outside.’”. The image of the “comfortable seal” (Pavlicevic, 2004) seems to invite contemplation of the consequences of a leak or, even more dramatically, a rupture. Indeed when a music therapist can acknowledge that in order to work appropriately and successfully within another context, a wider meaning of music therapy must be applied, a whole raft of issues rise to the fore. Quite simply, “The outside world is a part of the work that we are doing and, in fact, it is not outside at all; it is right here, within the room where we work. “Life” and “therapy work” are inseparable in the special, temporal or mental sense.” (Pavlicevic, 2004, p. 42).

The inherent complications and dynamic interactions of “inside” and “outside” were to provide many challenges during the work undertaken for Project Bethlehem, an ambitious

scheme situated in the West Bank, devised by music therapist and project clinical leader Claire Tillotson.

Project Bethlehem aims to provide training and resources in two areas:

- training local professionals working with children in the SOS Village and School in the town of Bethlehem in music therapy techniques;
- identifying a Palestinian musician suitable for music therapy training in the UK, providing the resources and personal support to enable this to take place.

Once trained the music therapist would have the chance to work in the SOS organisation, benefitting from the understanding of music therapy gained by staff during the other strand of the project.

The West Bank is a landlocked area located in the Palestinian Territories. Its name derives from the fact that it is on the west bank of the Jordan River. Since 1967, the majority of the West Bank has been under Israeli Occupation following the Six-Day War. In 1993, the Oslo Accords stated that the political status of the West Bank was to be subject to a settlement between the Israeli and Palestinian leadership, and there remain many issues relating to any such agreement that are still under discussion today.

One of the consequences of the political situation in the West Bank is that freedom of movement for work, education and pleasure is severely restricted. In addition to this, the construction of the Israeli Security Fence in 2003 has had a further impact on the import/export of goods, education and careers. Job opportunities are limited, and there are few manufacturing industries in the area. These conditions mean that many Palestinians suffer from emotional problems arising from their living conditions. There are also long-established refugee camps in the West Bank, comprising people displaced following the 1967 conflict. These are supported by UNRWA (United Nations Relief and Works Agency), but although basic needs are catered for, there are high levels of unemployment, mental health issues and concomitant social difficulties.

Bethlehem is nowadays far from the “Little Town of Bethlehem” image portrayed in the famous Christmas Carol. It is something of a sprawling urban development with a population of 30,000, including three refugee camps. It comprises three main areas: Bethlehem, Beit Jala and Beit Sahour, with a combined population of 60,000. In recent years many people from Hebron, a large town to the south of Bethlehem, have migrated to this area, attracted by the possibility of earning money from tourism. Because Bethlehem contains many sites that lie at the very heart of Christian belief such as the Shepherds Fields, where the Star signifying the birth of Christ was first observed and the Church of the Nativity, Baby Jesus’ birthplace, this is a not unreasonable calculation. The population increase arising from this migration has, however, put a strain on the already overloaded infrastructure of the urban centre.

There is no doubt that the social conditions and emotional states arising from this situation have a devastating impact on the lives and futures of the people of Bethlehem in general.

These effects are particularly noticeable in the behaviours of local children both in their homes and schools.

The lives of children living in Israel and the Palestinian Territories are hard for us to imagine. They continue to witness explosions, the shelling of houses, waves of arrests, civil violence and the constant presence of militia. In this atmosphere of conflict, little time and support is available for children to mourn their losses or to gain an understanding of the situation, and as a result many children remain emotionally isolated. Studies have found that a high percentage of children in the Occupied Territories show pronounced symptoms of psychological strain which require specialised therapeutic help.

Project Bethlehem Background

In early 2006, Claire Tillotson had instigated a training programme for healthcare professionals and educators in the West Bank. The idea for this Project had arisen from the McCabe Educational Trust, a charity whose remit is to provide enhanced educational opportunities for inhabitants of countries in which it organises pilgrimages. By creating a space where the music therapy techniques could be practised and thought about, she aimed to put in place a structure within which a music therapist could work, supervising staff using these techniques and carrying out music therapy sessions himself/herself. Presentations and workshops in Bethlehem had been well-received, with attendance at these events surpassing all expectations However, putting in place a more rigorous and wide-reaching training programme in the SOS Village and School; the organisation where the training was to take place, required a level of input that was not sustainable by two professionals with many other commitments. For this phase of the work a new partnership was created between Claire Tillotson, Project Bethlehem's business manager Canon Paul Miller and Music as Therapy International (MasTInt). It was decided to use MasTInt's model developed specifically for this kind of skills-sharing work following many successful such projects in Romania. This is set out briefly below. To facilitate this, a team of two comprising a music therapist (Elizabeth Coombes) and assistant musician (Hannah McCabe) were selected via a rigorous interview procedure to undertake this part of the Project. The team was fully briefed by the Project partners on how to implement the programme of work, and what the desired outcomes were to be.

Music as Therapy International

MasTInt was set up in 1995 with the goal of facilitating the development of music therapy in countries where music therapy provision was limited or non-existent. Local staff members in special schools and care homes were equipped with the skills, experience, materials and confidence to run music therapy programmes which could address the psychological, emotional and behavioural difficulties experienced by the children and adults in their care.

A model was developed, which allowed for a two-person team from the UK, consisting of a music therapist and assistant to spend six weeks with the local partners developing a music therapy programme that could then be owned and run by the relevant organisation.

The schedule for the six weeks is designed as follows:

Table 1: Schedule for the six weeks	
Week 1	Observation of the setting/s
Weeks 2/3	Music therapy sessions led by music therapist with local staff observing
Weeks 4/5	Local staff to lead all or part of the music therapy sessions
Week 6	Time to make up missed sessions/address specific issues

A booklet or other resources (DVD, visual aids) is also prepared by the MasTInt team that is individual to each project. This is left for staff, having been translated into their language, so that they have something to refer back to and use as needed.

Subsequent to the initial six weeks, and depending on the local partners' wishes, a follow-up visit may be offered once the staff had had a chance to lead sessions themselves for a period of time. This visit offers assistance with any issues that may have arisen, and, in conjunction with local partners, looks for ways to help and support this work in the future if needed.

The Local Partners

This term references the SOS Village and School. The following short description of the organisation provides some context for the work.

The SOS Children's Charity operates in one hundred and twenty four countries worldwide. Originally set up in the aftermath of World War Two, it describes its aims on the SOS website as being to provide "a loving home for every child." Each SOS Village consists of a number of houses each of which has its own House Mother. With the support of other health workers, she takes care of the children's physical and emotional needs. In Bethlehem, the SOS Village has twelve houses, with a maximum occupancy of nine children in each house. Many children do have families in the West Bank, but for various reasons it is not possible for them to be cared for in their family home. The SOS Village provides a substitute home environment that is nurturing and caring.

Each House Mother builds a close relationship with the children. She provides the security, love and stability that each child needs to develop emotionally. Brothers and sisters are kept together in the same home as far as possible to foster their filial relationships. When the children reach the age of fourteen, they move into nearby Youth Houses which continue to provide a home for the young people until they are able to stand on their own feet and live independently. For the rest of their lives, however, these children regard their House Mother as their parent and keep in close contact.

The SOS organisation in Bethlehem also includes a school catering for children from ages four to sixteen years of age. The total number of students attending the school is approximately four hundred and fifty, the additional children and young people being drawn

from the local community, generally comprising students from families who experience economic and social hardship.

Considerations in working as a music therapist in Bethlehem

As described in the opening paragraph of this article, there are many issues to take into consideration when delivering a project such as this. As a psychodynamically trained music therapist from the UK, I had worked with clients from a mixture of different cultural backgrounds. However, this was to be my first foray into working in another country. Additionally, the work was not just to provide music therapy, but to offer training for staff to facilitate them being able to work in this way when the Project's initial input was ended.

Pavlicevic (2004, p. 47) talks about how destabilizing working in unfamiliar territory can be. She is careful to point out that this occurs not only on professional and clinical levels, but that it also finds its way into personal and musical levels. "After more than twenty years of practice, I felt de-skilled, uncertain of how any of my skills might be useful or appropriate."

Zharinova-Anderson (2004, p. 234) states that a high degree of importance should be attached not only to the ethnic, social and cultural contexts, "but also all the contexts in which the work takes place – the therapist's background, the ethics of the institution in which the therapist is practising (Proctor, 2002) as well as the wider context of the village/town/city/country where the client, the therapist and the wider community live (Pavlicevic, 2002)."

Bearing all this in mind, it was decided to offer a structured training programme that could be modified by staff to suit the needs of the contexts in which they were working. In this way, they could adapt the methods they would be taught to suit their own ways of working, developing their individual style of music therapy, a process described by Brynjulf Stige (2010). I had been assured by Claire Tillotsen that working using music presented no difficulties, although the Village residents and students at the school were all Muslim. As I was relatively unversed in the techniques and styles of Arabic music, I felt uncertain about using melody and voice. Because my training and expertise is in Western music, I was unsure as to whether using my skills in this area would amount to an imposition of my own music on these populations. However, I felt that my training as a music therapist would help me to use my music therapy skills "automatically, in spite of myself"(Pavlicevic, 2004, p. 39).

One further point; the work of Winnicott is referred to during the course of the article. Although using such a culturally-specific theoretical stance may seem at odds with the thoughts expressed here, it felt important for my own professional persona that I had a familiar starting point from which to build and develop this work. This was to help frame further questions as the Project proceeded.

The Project in action

The UK team arrived in Bethlehem in late October 2009 in the company of Paul Miller and Claire Tillotson who were to accompany us for three days. They would help with orientation thereby facilitating a smooth commencement to the work.

As a result of the work already undertaken by Claire Tillotson in the West Bank, the local partners (SOS Village and School) felt that music therapy techniques could provide them with additional skills to help the children in their care. They believed that using music as a therapeutic tool would provide opportunities for emotional expression, exploration of attachment difficulties and the building of trust. It was hoped that at the very least we would be able to stimulate playful engagement with the instruments and each other. Perhaps this could enable the children to "gain mastery over their world and their lives" (Pavilicevic, 2002, p. 112) through the medium of play.

In the SOS Village and School, it was clear that previous training offered by Claire Tillotson meant that the idea of music therapy was firmly embedded in the staff teams. They were aware of its expressive non-verbal possibilities and eager to learn more. Without this strong foundation, it would not have been possible to provide such a detailed introduction to music therapy. In addition to this, having a good resource of musical instruments provided the opportunity to use a broad range of activities that were suitable to the skills possessed by the trainees. This was very important, as only one staff member was a trained musician. The instruments had been provided by money raised specifically for this six week project. All the instruments were purchased from music shops in the West Bank.

In order to provide a clear overview of the Project, the two settings in which the work took place will be described. Finally, an evaluation of the Project will be given together with some thoughts as to how best sustain and develop this work.

The SOS Village

For the duration of the Project, my assistant and I were accommodated in one of the Houses. This provided an excellent opportunity to observe the daily routines of the Village which was invaluable in formulating the therapeutic goals appropriate to this setting.

During a meeting in the first week with the three staff who were to receive music therapy training in this setting, the following therapeutic goals were selected for the work in the Village:

- expressing emotions in a safe contained environment;
- communicating and listening to others;
- developing self-esteem;
- developing social skills.

Staff members were aware of the possibilities of emotional expression offered by music therapy thanks to previous work done by Claire Tillotson. They also understood that improvisation with the instruments presented opportunities to nurture and develop social skills and self-esteem. They were keen to foster a group culture, with the idea of the group acting as a self-regulating mechanism through music-making. With this in mind, musical activities were developed that could help staff work towards these therapeutic goals. We also discussed working with individual children, something that the trainees were keen to try.

The SOS School

During the first week of work in Bethlehem, observations of school life were made by sitting in on lessons and watching what occurred during break-times. The class sizes varied slightly. Generally, however, there were approximately twenty five pupils per class. There were no classroom assistants. The students' concentration levels in the classroom were generally low, and they would get up and wander around or attempt to leave whenever they chose. Behaviour management was so time-consuming that in some lessons only ten minutes out of forty were dedicated to learning. The underlying tension present in many of the classrooms felt almost overwhelming, the teachers, however, were committed to delivering the curriculum as best they could.

Zharinova-Sanderson states that "we have to make efforts to understand the societies in which we are practising." (2004, p. 234), and this seemed even more important than in the Village, possibly because of the greater social mix present and also because of the need for learning to take place.

As in the Village, a meeting was offered in which goals for the therapy groups could be discussed. It was also suggested that staff members work with an individual in addition to a group. Initially, the trainees seemed unsure about working one-to-one. It was explained that working in this way with a therapist could enable children with problematic socio-economic and emotional difficulties to explore aspects of self. This could then be helpful when thinking about the children's difficulties in a group setting. Possibly the idea of working one-to-one was actually counter to the cultural norms present in this setting, as the idea seemed new to them, even though Claire Tillotson had undertaken some individual work in both School and Village. It may also have been that timetabling difficulties presented challenges in arranging one-to-one sessions in the School.

In the event, all those to be trained agreed to work with an individual as well as groups after this meeting, and the following therapeutic goals were set:

- to encourage listening, watching and waiting;
- to improve focus.

Some further explanation of these goals seems necessary.

The rather general statement in the first bullet point was selected by staff to provide some help in maintaining status quo in the classroom setting. As previously mentioned, difficult behaviours were a norm in lessons. Staff wanted to find new ways to reduce these behaviours and provide a situation more conducive to learning. These were, then, areas in which they felt students could make progress with the help of music therapy.

The term "focus" was one referred to by staff in the School and Village. While it does refer to concentration within the classroom setting, it also has a broader connotation. It embraces the idea of having a goal you wish to achieve in life, of having a direction or dream for the future. This seemed to be a very important idea in the minds of the staff, and it was

possible to see why when the circumstances of the wider social setting were taken into consideration.

Something that the staff team was not at this stage able to think about was the notion of creativity and free play within these music sessions. A quote from Ralph Waldo Emerson, the noted Nineteenth Century American writer, came to my mind when observing the children here and in the Village; “It is a happy talent to know how to play” (Emerson, 1835, p. 116). I felt the ability to play was not fully developed in many of the children we worked with in the School and Village. Giving children a space in which they could play would facilitate healthy emotional development and growth, as demonstrated by Winnicott’s theories.

In his work “Playing and Reality”, Winnicott states that “Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play.” (Winnicott 1971 p38).

Although the Project aim was not to train staff as psychotherapists or music therapists, it felt important to raise staff awareness of the importance of this aspect of music therapy. It seemed, however, important to start sessions before discussing this with them. Because of the very structured school day and the didactic nature of the educative style in the school maybe staff members could divine this for themselves. Perhaps then they could value it more and perceive its benefits, as they had come to this idea through their own experience.

SOS Village Clinical Work

At the initial staff meeting, three team members were identified as being available for training. Each one worked with one group and individual. The team in the Village consisted of a psychologist, a social worker and the activities organiser. The last of these was the only male member of the team.

In this setting, staff availability was more problematic. Although weekly feedback meetings were scheduled, only two such gatherings took place. Also, no evaluation meeting was possible in the last week due to staffing issues. This was unfortunate as this meant there was no opportunity for staff to voice their feelings about the work and its future.

No formal observations were undertaken in the Village. As such, this seemed unnecessary as we were living there, and so could see and participate in the daily routines experienced by staff and children. The social worker took on the task of choosing the children to participate in this Project. These selections appeared to be highly appropriate.

It was initially difficult to set up a timetable in the Village. This was because no children were available for work until after lunch, and staff had varying availability. Staff also finished work by 4pm, so this put further constraints on the timetable. Eventually, however, a timetable was established, although it did not remain consistent throughout the six weeks. It felt more important to get the work done without being too rigid about the timings; this

could be stressed in the weekly meetings. As the Project drew to a close, however, these issues were being resolved, and it was becoming more apparent when would be good times to hold sessions.

As a whole, staff clearly had the ability to undertake this work. It was difficult in the time available to support staff in allowing the children to be the focus of the music and to follow their leads. It was clear, though, that staff were playful and eager to learn. Having a psychologist on the team meant that there was the opportunity for her to use her keen analytical eye to see what the therapeutic goals might be and how they could be achieved using music. An issue in the Village was the lack of a trainee with really good English; this did not seem to affect the workshops themselves, but it would have been helpful to have been able to give and receive more detailed feedback.

The sessions lasted for thirty minutes. This seemed to be the maximum time that the children could safely be contained and focussed in the space available for the work. It was difficult to ensure those not included in the sessions did not intrude into the therapy room, and on some occasions the Project assistant was employed to engage those not involved at that time in play outside, so that the work could continue uninterrupted.

Each session began and ended by using a Singing Bowl, a bronze vessel that sits comfortably in the palm of one's hand. It is then played with a wooden stick, eliciting a ringing sound. This was passed around for everyone play if they so wished. I specifically brought this instrument to Bethlehem in order to use it to create a separate musical space that was clearly defined, and to offer the idea of taking turns, waiting and listening. Few people in the SOS were familiar with this instrument, although after a few sessions, it became strongly identified with the music therapy work for staff and pupils alike. From a theoretical point of view I was thinking of Winnicott's "facilitating environment" (Winnicott 1965 p223), not just for the children, but also for the staff. Although I felt that Claire Tillotson had already been internalised by staff as a "good enough" mother, (Winnicott 1958 p78), now was the time for the idea of music therapy itself to become part of life at the SOS Village and School.

As the Singing Bowl was passed around, opportunity was given for people to introduce themselves if they wanted, to talk about something they had done or say how they were feeling. This and the other activities used in sessions can be referenced through the Project booklet. It is included as Appendix.

Although the basic shape of the activities was clearly explained, small developments were introduced during the Project, and, as they became more confident, by the staff themselves. It felt important not to overwhelm the trainees with ideas, but to show that a relatively small number of activities had an almost endless range of possibilities. As the time went by, the idea of improvisation was introduced to staff, and they were keen to use this technique. They began to see the value of this aspect of the work as it enabled relationships within the group to be worked on more deeply. By the end of the Project, staff appeared to have had sufficient input to enable them to lead sessions themselves.

Individual sessions were also initially programmed for thirty minutes. However, it was explained that this might be too long, and that staff should be flexible but consistent as to

the length of this aspect of the work. Again, a strong structure was given to the sessions so that staff had a "secure base" (Bowlby 1973 p407) from which to build. It was suggested that improvisation be more of a feature in the individual work, so that the child was offered more autonomy if appropriate.

Set out below are some case studies of the work in this setting.

Case Studies – SOS Village

Maya

Boy and social worker in the SOS Village

Maya a twelve year old girl with learning disabilities was chosen as the psychologist's individual client. Maya's mother had died at birth, and her father had abandoned her. She had come to the Village two years previously having never attended school. I was told that Maya had been abused physically and sexually, and had violent tendencies.

In the first session, Maya sat as though frozen in her seat. She was wary of her surroundings, even though she was very familiar with the room in which the work took place. She continually looked behind her and was nervous at the changing light and shadow in the room. However, she engaged with all the activities, although her attention span was short. She was demanding, and once she had decided she had finished something, she could not be cajoled into continuing or restarting.

The following week, Maya appeared more comfortable in the setting. She became much more domineering and physically aggressive, dictating what was happening. She was unable to share instruments and demanded that everything be done a certain way. After this session, I explained to the psychologist that we needed to gain Maya's trust. This would help her have positive experiences of relationships with people that were mutual and not dependent on one dominating another. I could see there were enormous possibilities for Maya to develop her social awareness and explore her emotions using Music Therapy.

The psychologist was unable to attend session three, so I undertook that alone with Maya as she was very eager to work with music. With just the two of us there, Maya became even more demanding and aggressive, but was able to tolerate and show pleasure in sharing the small ocean drum. We also developed a "Hiding the Eggs" game, much to Maya's delight.

This involved using the small egg shakers. One person hid them around the room while the other person had to find them. Maya really enjoyed this activity, and was able to participate in it for a substantial length of time. As I worked through this game with Maya, I reflected that it felt as though no one had ever played with her like this before.

The fourth session was led by the psychologist. We used a wicker music box to contain the instruments as an aid to assist Maya in understanding boundaries and endings. The trainee herself seemed a little unsure of how to play with Maya, and the episodes of play she undertook with Maya could, I felt, have been extended. This was probably a confidence and practice issue; with experience, this aspect of the work could be developed. Certainly at the end of the sessions, the psychologist remarked “It is good to play with Maya. She needs much play”. I felt this showed that the benefits of working in this way with Maya and her problems had been understood, and hoped the work could continue. These experiences, in my view, could help Maya become better integrated into Village life as she developed her ability to form positive trusting relationships with adults and peers.

Group Led by the Activities Organiser

Group in the SOS Village

This group took place on a Sunday afternoon. Unfortunately this meant the trainee withdrawing from playing with the children to come into the activities room. The effect of this was that throughout the session, the children climbed up the doors and tried to gain access to the room, necessitating a lot of interruptions to the process as we tried to protect the space.

However this trainee engaged very well with the music and the group. There were three boys and one girl in the group, the girl being a very able and strong character. She often tried to dictate the content of what the boys were playing, pairing with one of the smaller boys to provide a characteristic beat to the free play. The Activities Organiser managed this well, finding ways of bringing the other children’s music to the fore, and added some delightful vocalisations to the instrumental mix. He was particularly sensitive to group members who had poor motor skills. One boy in particular, Abed, was easily frustrated by his lack of rhythmic awareness. The trainee was able to use his own playing to support and reflect the character of Abed’s music, and made the music space somewhere where Abed could have a satisfying experience and feel heard. This was in stark contrast to Abed’s school life, where he was considered disruptive and troublesome.

Comments on Music Therapy in the SOS Village

It was difficult to establish a programme of work in the Village, partly due to the lack of knowledge amongst staff of the following conditions:

- when the activities room was being used by someone else;
- when the children were available for sessions;
- ensuring the instruments could be accessed if staff were out on home visits;
- staff finishing work by 4pm which meant that there was not much time after school to involve them in the work;
- the difficulties of preventing those not receiving sessions from entering the activities room.

However, it seemed that in this setting, the staff team was more able to think about the emotional lives of the children. There was much more opportunity for children to receive lengthy courses of music therapy as opposed to the school where they wanted a shorter programme of work to ensure the maximum number of children who could benefit did so. The problem of access to the instruments was solved by commissioning the making of a music hest by local carpenters out of olive wood. It is lockable and mobile, having wheels. This will ensure that the instruments are easily available for use.

It is clear that the potential and willingness to build on this work is there. With careful planning and support, there is every chance that music therapy can become an integral part of Village life.

SOS School Clinical Work

As in the Village, three trainees were selected. They consisted of the School social worker, the music teacher and the special needs teacher, the last of these being the only female on the team. Of the three trainees, the social worker had the opportunity to participate in many more sessions than the other two trainees because he was not tied down to a teaching schedule. Despite being very busy, he managed to find time to work with eight groups and one individual in a week. The other two trainees worked with one group and one individual. Scheduling sessions was more problematic with the music teacher as his position was only part-time. This meant making up any missed sessions was very difficult. A weekly staff meeting was also timetabled, although due to staff availability, only two meetings were held. Fortunately, the social worker was always eager to discuss the work and feedback to the project team. This meant that there was the opportunity for dialogue and discussion and a place where the work could be reflected upon.

Structure of the Sessions

Due to the fact that only one of the staff was a musician, it seemed important to give the work a strong structure to facilitate learning. Although it was possible that that this could work against the idea of a musical dialogue created through improvisation, giving staff a safe haven from which to begin their journey into music therapy felt just as valid.

Each session lasted for forty minutes, the same length as a lesson. Initially I thought this would be too long, but staff explained that the whole lesson time had to be utilised; it would be too disruptive for pupils to return to a lesson with only ten minutes left. I decided to conform with this to begin with, thinking that if it were untenable, maybe we could revisit this aspect of the schedule. In the event, forty minutes proved satisfactory for groups, although two of the three individuals struggled with the length of time. Staff agreed to monitor the length for individuals with twenty minutes being the minimum space offered.

As above, brief case studies are set out below, showing how the work developed in the School.

Case Studies – SOS School

Hissein

Boy and teacher in the SOS School

The music teacher worked with Hissein, a twelve year-old boy. Hissein had lived in the Village from babyhood. He was the youngest of seven children. His mother had died when he was a baby. His father's subsequent remarriage had meant the children by his first wife were put into care. Hissein was a very likeable child who tried hard at school but found it very difficult to concentrate in lessons. His lack of academic achievement was a source of upset to him. Also during the time we were at the Village, his housemother of five years left, leaving Hissein tearful and angry.

I felt Hissein, who enjoyed music and had a good degree of skill in rhythmic playing, could benefit from one-to-one sessions. It could help him build a positive relationship with his teacher, and see school as somewhere where he could achieve.

At first the trainee did not understand why he was working with someone who was so musically able. I explained that music therapy was not concerned with the level of musical skill shown by a child; the goals were completely different. Gradually he was able to accept this concept and work with it. I felt it also helped him explore the therapeutic possibilities of co-improvised music.

Hissein found it difficult to use the Singing Bowl space to express himself verbally. Indeed, it became clear as the project progressed that the tension between providing a satisfactory

training experience for staff and at the same time ensuring that clients were also catered for was an enormous challenge. In hindsight perhaps more time spent with the trainees helping them devise activities might have stimulated the emergence of a more culturally and contextually specific programme.

However, Hissein was very quickly able to engage with the musical activities, showing tremendous enjoyment of the following and leading roles. Soon it was possible to use free play with Hissein, moving between more rhythmically based improvisations and melodic lines. This enabled the teacher to see the musical and expressive possibilities in using this way of working; a way that was completely new to him. It meant that not only was Hissein able to begin building a positive non-verbal relationship with his music teacher, but that the teacher himself was also able to learn from his time with Hissein. An important moment in their work together, I felt, was when the teacher gave Hissein a melodic phrase to play while he improvised; the roles were then reversed. I had reservations about this when the idea was introduced; I thought it would be too difficult for Hissein. I was proved wrong. Showing great concentration, Hissein was able to perform this complex task. “I asked him because I knew he could do it”, his teacher said, then went on to talk about the emotional and creative possibilities of working in this way. It was clear that this brief introduction to music therapy had touched a chord within the teacher. Subsequently he was eager to learn about future training opportunities that could be offered in Bethlehem and the UK.

Grade 10 Group

Boy and Liz Coombes in the SOS School

The social worker wanted to work with a group of pupils aged fourteen who were all disaffected and difficult to manage in class. Indeed, they were so disruptive that any class they attended had no chance of becoming a place where learning could be facilitated. The group, comprising one girl (Samira) and three boys (Firaz, Mustafa and Hamza) received four sessions, although the last one was only attended by Samira and Hamza, the others being away because of a religious holiday.

At first I was unsure whether to change the activities I was offering as the students were teenagers. I worried that the students might find them babyish and irrelevant and therefore not wish to engage. Again, the tension between delivering a training project and respecting the needs of the clients’ became evident to me. I felt that the main focus of the project was to facilitate the continuation of this work after the team had left, so decided to keep to the

established structure while being responsive to the mood and needs of the group. In the event, the group members engaged wholeheartedly with the work we did. The difference with this group to the others was, however, that they rapidly became more able and desirous of improvisation, and therefore this became a strong feature of the group's experience.

After the initial session, Firaz said that this was the first time he had ever played music, and although I found it hard to believe this as I am sure he had had music lessons at School, the remark made me realise that he had deeply experienced the music and connected with it. Within a very short space of time, the group were able to improvise together, with some interesting pairings. The trainee encouraged them to make use of the piano as well. When Hamza expressed an interest in playing it the trainee went to the instrument to support him in his playing. As this staff member was in fact not a musician, I felt this showed great commitment to the idea of using music therapeutically, and no small amount of courage.

Hamza had considerable issues centring around self-esteem and confidence, and this manifested itself in excessive clowning in class. He was quick to seize on an opportunity for merriment and mockery, but not in any seriously unpleasant way. I imagined, however, that it might be very difficult to work with him in a class. I noticed that he had a tendency always to have the last musical word; whenever an activity was finished, he had to play another note. I remarked on this at the end of the session with the Singing Bowl, and was told that Samira had also raised the same point when she commented in Arabic on the group. This was a highly fortuitous coming-together of opinions, expressed in a very tolerant, light-hearted way. Hamza seemed pleased that he had been recognised in this way; it felt as though the group were moving towards an understanding and deeper knowledge of each other. The group were very keen to continue their work using music in this way, and a promise was made to them by the social worker that sessions would recommence in January.

Comments on Music Therapy in the SOS School

Staff members were eager to have the chance to learn these new skills. Other teachers also asked about training in these techniques. Positive experiences with Claire Tillotson meant that they were highly enthused by the work. As a whole, the trainees were extremely willing to try everything that was offered to them. This positive attitude rewarded them, as even in such a short space of time, improvements were reported by other teachers in the students the trainees had worked with. Pupils were thoroughly engaged in the process, and eager to attend the groups. The trainees asked class teachers for feedback about students involved in the scheme, and positive comments were received, detailing less violence in classroom situations, more positive attitudes shown in class and better "focus". An evaluation meeting on the last day with the Deputy Head-Teacher was very encouraging. The staff members described their experiences in glowing terms, and were very upbeat and hopeful about the potential for positive changes in pupils with continued participation in this programme.

Difficulties encountered in the School were minimal. Often on arrival the timetable would have to be drastically changed because staff members often had to deal with unexpected situations. This had a deep impact on the schedule. Before the routine at the school became

familiar, it was difficult to negotiate practical matters, but after a week or so it was possible to locate the people who could help with these issues. This meant that any problems faced at the SOS School were fairly easily solved or negotiated.

With regard to the trainees, there is no doubt that the social worker was the most enthusiastic member of the team. He had the chance to participate in many more sessions than the other two teachers, and therefore his progression in acquiring the necessary skills and knowledge was much quicker. The special needs teacher, although initially lacking in confidence, quickly realised that these skills were within her capabilities, something we were in no doubt about having observed her teaching. Although the music teacher participated in fewer sessions than these two trainees, he too was able to grasp the possibilities of this work.

On returning home, notification was received from the SOS that they were planning to restart sessions after Christmas 2009. A schedule was indeed set up, and sessions were run from January right up until our return to Bethlehem in May 2010 for a follow-up visit.

Overview

In the view of the UK team, staff members and children made significant progress during the six weeks of the Project. This opinion was supported by empirical evidence from the teachers and other health workers in the SOS. On arrival in October 2009, expectations were kept low if all that happened was that staff and children had fun with the instruments and people were encouraged to make music, then that would be sufficient. As it was, all staff led at least half of a session, with those at the School leading one whole one themselves. It can be seen from the booklet that a variety of issues key to the development of this work were covered. All the aspects covered in the booklet directly related to questions that arose during the sessions. As far as was possible, the booklet was tailored to suit staff members' needs and help them begin to make the work their own.

There were a number of questions asked by the trainees at the end of the project: "When are you coming back?" "Can we come to the UK and see music therapy in action?" "Can we come and see how your schools work?" These remarks show how valuable this work has been; what needs to be determined now is how to sustain and develop it in a way that is appropriate to the setting.

The Follow-Up Visit May 2010

A positive response was received by MasTInt from SOS regarding the possibility of a follow-up visit by H and me. Early May 2010 was identified as an appropriate time to visit, coming as it did several months after our original training and before the school examination season got underway. The Project team therefore travelled to Bethlehem for one week with the aim of observing sessions and identifying areas of need for the staff's further development.

Certainly, after the six weeks intervention of the previous year, it felt strange to be only visiting for one week. What could actually be achieved in such a short space of time and

would further progress be made? Additionally had staff been running music therapy sessions? And if so, how were they going?

The SOS School

During the week-long visit two staff meetings were held, and each staff member was observed undertaking two group sessions. No individual sessions had been carried out as it seemed that staff did not feel comfortable working in this way, nor was it possible to fit this into the school timetable. It is possible that cultural considerations were an issue here, but there was not enough time, in the event, to investigate this aspect of the work. It was noted that the two teachers were actually doing music therapy sessions in their free periods in addition to the classes they had to take.

Of the work that was observed, it was clear that staff had found the booklet invaluable. Although they had not stuck slavishly to the activities offered, it appeared that this had provided a "good enough" (Winnicott 1958 p245) support, a "secure base" (Bowlby 1973 p407), if you will, from which they could develop new activities. It was possible to see that the children had made great strides in terms of working creatively, interacting appropriately and extending their concentration in the music therapy setting as the staff team had continued working with some of the same students. An important factor gleaned from observation was that staff members were also enjoying using music as a therapeutic tool.

In the final staff meeting at the school, the following suggestions were made by the MasTInt team:

- that the music therapy sessions be programmed into the teachers' teaching schedules;
- that a monthly team meeting be scheduled where experiences, both positive and negative, could be shared;
- that a further support visit from our team be arranged early in 2011 to address specific issues and investigate how to provide other teachers with the knowledge and skills to carry out this work.

The SOS Village

On returning, it was found that only one staff member was using music therapy. The psychologist and activities organiser both felt they were either too busy or that the work was not appropriate to their role in the Village. Subsequent discussion revealed that the psychologist's role within the Village was ordinarily confined to working with the House Mothers. She stated she did not have time to programme in music therapy sessions with the children, and in any case, this was not her job. The activities organiser was rather more vague as to the reasons why he had not continued with the music therapy sessions. He simply stated he was too busy. Further enquiry revealed that generally any work considered to be therapeutic in the Village was carried out by the social workers. We wondered, therefore, why the psychologist and activities organiser had been selected for training if their roles did not allow for continuing practise. It may be that there was some issue of communication between the Village Director and staff, or, perhaps more likely, some

underlying dynamic cause that we were unable to locate during the brief time of the project. However, the opportunity had been provided for staff members to try out these techniques, and maybe at some point in the future they might feel able to begin working in this way. At least they had a store of instruments to use and a portable music chest in which the instruments could be kept.

We observed the social worker leading one music group, although she had actually programmed in three groups and one individual per week. Using the booklet as a guide, she had invented many new activities, largely concerned with communicating effectively in pairs or resolving areas of conflict through playing music together. It was exciting to witness music therapy techniques being so confidently owned, and the development of the activities we had introduced. Again, the children were very eager to take part, even though some aspects of the session were clearly difficult for them emotionally. Because it was possible to observe some of the same children previously worked with, positive changes in their behaviour in the areas of social skills and emotional expression were noted.

For example, Abed, who had attended a group during our first visit was now able to attune his playing to others in the group more easily. When he struggled with holding to the group rhythm, he was able to recognise this and take his time to find a way of joining in with the music without becoming so visibly frustrated. Also, the children had formulated a series of written boundaries for the group, and had also given the group a name, “Tolerance”. This seemed very much in keeping with the theme of the activities the social worker had worked on.

In a meeting with the social worker, I made the following suggestions:

- that she ask if she might observe some sessions at the school. This would reduce her feeling of isolation, being the only person using these techniques in the Village;
- that she revisit the booklet, familiarising herself with some of the activities that used the idea of creating a space for emotions to be shared verbally. I suggested this because her music therapy working style relied on verbal discussion.

Conclusion

Because this Project is a living, growing entity, it feels very difficult to write a conclusion. In each setting in the SOS, the work has progressed differently, reflecting the needs specific to each component part of the organisation. It may be that this will continue. What we can say is that as local partners begin to own the music therapy work, exciting possibilities will arise.

Working creatively and therapeutically has benefitted not only the children participating in the work, but also the staff teams. They themselves have expressed satisfaction that the Project has provided them with opportunities to explore new ways of working. It will be interesting to learn what impact this has had on other areas of their work and of course, to see how music therapy develops as the other strand of the project comes to fruition.

With regard to my own work on this Project, as I have stated above, the task I was charged with led me to question my role and professional abilities as a music therapist. An emerging

need and role that I fill has continued to grow throughout my continuing contact with the people I worked with in Bethlehem. This is best described as “to be there in order to listen to and share what (they) live through every day; to receive and witness their lives” (Pavlicevic 2004 p 40). My thinking to date around this Project has been that this is one of the most important aspects of my work there, and one that I feel a music therapist is eminently suited to fill.

The booklet prepared by Hannah McCabe and myself and left as a resource for the staff teams contains a page on which the words “Wait. Watch. Listen.” are writ large. I feel these words are and will continue to be my guidelines for any continuing support I am asked to give to this Project.

Acknowledgements

This work would not have been possible without the full support of all partners involved with every aspect of the Project.

I would also like to thank my husband, Dr Stephen Glascoe for his support which made the challenges of working on this Project weigh less heavily on my shoulders.

On the ground in Bethlehem thanks are also due to Issa Mussallam. His local knowledge and help with practical matters greatly facilitated the music therapy work.

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Appendixes

1. Appendix : Music as Therapy. Trainee Handbook (pdf 189KB)

E-ISSN 1504-1611

Published by GAMUT - Grieg Academy Music Therapy Research Centre (NORCE & University of Bergen)

Coombes, E. (2011). Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank. *Voices: A World Forum For Music Therapy, 11*(1). Retrieved February 16, 2011, from https://normt.uib.no/index.php/voices/article/view/291/445

APPENDIX B

MUSIC AS THERAPY

Trainee Handbook

SOS School and Village

Bethlehem 2009

By

Liz Coombes

Coombes, E. (2011). Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank. *Voices: A World Forum For Music Therapy, 11*(1). Retrieved February 16, 2011, from https://normt.uib.no/index.php/voices/article/view/291/445

INTRODUCTION

We have devised this booklet to help you continue using **Music as Therapy.**

It covers everything we have worked on during the project, including:

- **Music as Therapy** principles
- **Music as Therapy** activities
- Suggested ways to support your **Music as Therapy** Teams
- Ideas as to how to develop this work

We have enjoyed working with all of you and very much look forward to hearing how your work using **Music as Therapy** develops.

Best Wishes,

Liz

Coombes, E. (2011). Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank. *Voices: A World Forum For Music Therapy, 11*(1). Retrieved February 16, 2011, from https://normt.uib.no/index.php/voices/article/view/291/445

WHY MUSIC AS THERAPY?

"Music is the language of the soul." This phrase was communicated to us in one of the first conversations we had here in Bethlehem, and it summarises perfectly the reasons for using this creative intervention here in Palestine.

The ability to respond to music is within us all. Everyone has the potential to be drawn into active music-making and therefore to experience a musical relationship with the therapist and others.

Through creative music-making and musical activities, shared experiences promote self-expression and social-skills.

Research has shown that positive changes in emotional health and behaviour can occur when children are engaged in therapeutic music sessions.

Here, at the SOS Children's Village and School, we have worked with two teams to devise programmes of work that can support therapeutic aims relevant to the children and young people you have in your care.

Coombes, E. (2011). Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank. *Voices: A World Forum For Music Therapy, 11*(1). Retrieved February 16, 2011, from https://normt.uib.no/index.php/voices/article/view/291/445

PRINCIPLES OF MUSIC AS THERAPY

Music as Therapy is child centered

This means that the needs and wishes of the child are the focus of the sessions. To facilitate this, think about these words…

WAIT

WATCH

LISTEN

As you become more experienced you will be able to respond musically to these concepts by:

MATCHING

- Try to match the children's music.

DEVELOPING

- Try to develop the children's musical ideas.

Working in this way will create a therapeutic relationship and musical space where you can work with the children to achieve your therapeutic goals.

The sessions should always have consistency:

- SAME TIME
- SAME PLACE (make sure you have booked the room in advance if you need to).
- SAME INSTRUMENTS
- NO INTERRUPTIONS
- KEEP SOME ACTIVITIES THE SAME FROM WEEK TO WEEK
- INTRODUCE AND DEVELOP NEW ACTIVITIES TO MEET YOUR THERAPEUTIC GOALS

Practical reminders to help you with your sessions:

Make sure that the musical instruments are accessible to you and that you have chosen which instruments you will use before the session starts.

A good idea is to have your chosen instruments in a box – this will make it easier to move them around and to put them away when the session is finished. Most importantly it will also help establish the boundaries of the session; for example, when you put the instruments back in the box the child will know when the sessions has finished.

If a child particularly likes a certain instrument, ensure you make it available to them.

Remembering these practicalities will ensure that Music as Therapy sessions provide a space where therapeutic goals can be achieved.

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Confidentiality:

Music as Therapy sessions are confidential. Of course, you can share aspects of this work as necessary with those involved professionally and personally with the child. However, please ensure any such discussions respect these professional boundaries.

THERAPEUTIC GOALS

When working with a child or group you may wish to select three goals and work with these initially. Keep it simple - choosing too many may confuse you!

Possible therapeutic goals:

- To increase self esteem and confidence
- To develop communication skills
- To develop social skills
- To explore and express emotion
- To develop creativity
- To interact with other people without being aggressive
- To help children understand boundaries

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How do I select children to receive

Music as Therapy?

Consider the therapeutic goals we have suggested in this booklet and then

trust your instincts.

The choices you all made regarding the children we have already worked with have been highly appropriate! If you use the same criteria as you did this timeyou will continue to work with children who will benefit from Music as Therapy.

Group or Individual?

Each Music as Therapy trainee has already worked with at least one group of children and one individual child.

In order to decide which form of therapy is appropriate for the child consider the therapeutic goals for that person.

As above, we suggest you **trust your instincts.**

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MUSIC AS THERAPY SESSIONS

How long should a session last?

At the School, we initially worked with individuals and groups for forty minutes, the length of a school period. While this was suitable for groups, for some individuals this was too long. In their cases we made the sessions shorter so that the children could have a satisfying musical experience.

At the Village each session lasted for thirty minutes. Again this worked well for the groups however, was too long for some individuals. As above, sessions were then made shorter to suit the needs of the child.

Should I tell the children why they are coming to Music as Therapy sessions?

We have discussed this issue with you and decided that it is a good idea to explain to the children that making music together can help with things that may be difficult or scary. Particularly at the SOS School, we discussed asking the children what things are challenging for them at School. Most importantly keep things positive and make sure that the children do not feel they are receiving Music as Therapy sessions because they are bad or naughty.

How do I structure the Music as Therapy sessions?

It is a good idea to have an opening and a closing activity, such as **Say and Play** or **Follow me**. Some of you have used **Say and Play** to provide a space at the end of the session for discussion. You have learned a range of activities that you can use throughout the sessions. You have chosen when to use these based on the needs of the individual or group on that day. Continue working in this way – you are all on the right track. As you become more confident, you may feel able to ask the children what they would like to do in the group sessions.

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HELPFUL HINTS!

DON'T BE A TEACHER:

Music Therapy is not about teaching a child how to play music. Do not concentrate on teaching the child how to play the instruments, try and let them work it out for themselves.

SILENCE IS FINE:

Silence is an important part of music. Do not worry if the music stops for a while just wait and see what happens.

LISTEN:

Listen to the character of the music that the children are playing and try to match it.

SUPPORT THEIR MUSIC:

Try not to impose your own ideas or lead the music during **Solos**, **Duets** or **Free Play**. Allow it to develop and support the child's music.

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Evaluating Your Music as Therapy Sessions

Making notes:

It is a good idea to get in the habit of keeping notes after every session. Overleaf is a form we have used to record the details of what happens in the work. You can use this if you wish or if you would prefer please find another way of keeping your notes.

Achieving your goals:

Check how those receiving Music as Therapy sessions are doing in classes, at home or in the village by communicating with families, teachers and other professionals involved in their care. This will help you to know whether progress is being made.

Music as Therapy Team Meetings:

Ensuring regular meetings for your teams at the School and Village take place will help you evaluate your work through discussion. This will also facilitate staff development and can boost your confidence as you share ideas.

Reviewing the Sessions:

Together, we devised a plan to evaluate the work empirically and through reports after six weeks. Following another four weeks work further evaluations that compare progress with the relevant therapeutic goals will help you decide how long to continue working with a child.

Ending Therapy:

It is important to give the children at least two weeks' notice that Music as Therapy sessions will finish. You felt this was manageable. It may be that you find this is not long enough and therefore four weeks needs to be considered as an appropriate length of time.

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SESSION EVALUATION FORM

Date:

Session Number	
Names of Participants (who attended the group/individual session)	
Description of activities used	
Evaluate the session – how did it go?	
Plans for the next session – What might you do next time? Keep it the same, change some things,	

THE MUSICAL ACTIVITIES

SAY AND PLAY

WHY:

To create a clearly defined beginning and end of the session.

WHO:

Group and Individual sessions.

EQUIPMENT:

Singing bowl or rain stick. *See variations below.*

HOW:

Choose one instrument for this activity. Each person says their name, then plays the instrument. When the sound of the instrument has ended, the instrument can be passed to the next person.

VARIATIONS

The individual/group member could play the instrument in a way that

expresses how they are feeling that day.

Each individual / group member chooses the instrument they want to play

for this activity from a selection available.

When the group members are comfortable with each other, you can ask people to make a verbal statement of some kind, if this suits the therapeutic aims of the group/individual you

are working with. For example, they could share with others something they did since the last session, or say how they feel on that day. The musical space you create by listening and waiting means that the individual/group members have a space they can use to express themselves verbally if they want to.

FOLLOW ME

WHY:

To develop listening and waiting skills and the ability to wait for your turn.

WHO:

Group and Individual sessions.

WHEN:

Near the beginning of the session as a warm-up.

HOW:

Using only parts of your body (hands, feet, etc) ask the group/individual to follow your movements and sounds. You can then ask the other group members/ individual, if they want to be the leader.

Variations

- When the individual/group is more confident, ask who would like to be the leader to start the activity. After leading, each child can then choose who will be the next leader.
- Use instruments instead of body percussion.
- Use vocal sounds instead of body percussion/instruments.

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SOLOS

WHY:

To develop confidence and creativity in the player/s together with listening skills.

WHO:

Group and Individual sessions.

EQUIPMENT:

Windchimes or xylophone. *See variations below.*

HOW:

Choose an instrument and ask if the individual/anyone in the group would like to play a solo.

Variations

- Ask the child/children to choose an instrument
- If in a group, ask the person who has played a solo to choose who could play next.
- You could ask the rest of the group what they thought of the music

  they just heard, what it made them think about and how it made them feel.

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DUETS

WHY:

To develop communication skills, waiting, listening and creativity.

WHO:

Group and Individual sessions.

EQUIPMENT:

Xylophone and wind chimes. *See variations below.*

HOW:

Version 1 - Ask a child choose an instrument and then the leader plays with the child.

Version 2 – Choose two instruments and ask 2 children to play together.

They listen to each other and improvise together. They can make up their own music; one does not need to copy the other.

Variations

FOR A GROUP SESSION:

- Ask a group member to choose who they would like to play with.
- Ask one group member to use voice, the other an instrument.
- Ask three people to play together.

- Ask the group members what they thought of each other's music and

perhaps what it made them think about.

PASS THE NOTE

WHY:

To develop creativity, listening skills, the ability to wait and take turns.

WHO:

Group sessions.

EQUIPMENT:

Chime bars and beaters.

HOW:

Give everyone a Chime Bar and a beater. Start by going round the group with each person playing one note in turn. Then, using gesture and eye contact pass the note randomly to others in the group. End the activity by gesture or by getting everyone to play together, then stopping with dynamic, a countdown or gesture.

Variations

- Play different patterns and develop listening skills by playing two,

  three of four notes at a time.

- Experiment with different dynamics by playing loud and soft notes.

- Use the castanets instead of the chime bars.

- Use vocal sounds as you pass the notes (zzzzzip, sshhhhh, toot etc)

- Experiment with exaggerated facial expressions and body movement.
- Use your voices instead of instruments.

FREE PLAY

WHY:

To encourage free expression, a sense of self, a sense of being in a group and an understanding of the effect each person has on another.

WHO:

Group and Individual sessions.

WHEN:

When you think the group is ready to play freely together in the session.

HOW:

Offer the group/individual a selection of instruments. Explain that everyone will play music together. You may wish to tell the child/children that you will mark the end of the improvisation by giving a signal. This could be, for example, choosing an instrument you will play to signal the end of free play. When working with an individual, you may wish to allow them to decide when to end the music.

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INTERNET RESOURCES

Music as Therapy

www.musicastherapy.org

The Association for Professional Music Therapists:

www.apmt.org

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Music as Therapy

The Co-op Centre

11 Mowll Street

London

Coombes, E. (2011). Project Bethlehem - Training Educators and Health Workers in the Therapeutic Use of Music in the West Bank. *Voices: A World Forum For Music Therapy, 11*(1). Retrieved February 16, 2011, from https://normt.uib.no/index.php/voices/article/view/291/445

SW9 6BG

UNITED KINGDOM

Article

Interactive therapeutic music skill-sharing in the West Bank: An evaluation report of project Beit Sahour

Elizabeth Coombes & Michal Tombs-Katz

ABSTRACT

Interactive therapeutic music skill-sharing projects are becoming more widespread, yet there exists little research into the areas of trainees' motivations and transfer of skills, aspects that seem vital if the projects are to achieve their goals of upskilling employees and benefitting clients. Project Beit Sahour (2012 – ongoing) aimed to equip teachers and social workers with skills to run such groups in their workplaces. This paper provides an evaluation of the project that took place in the West Bank in two mainstream schools, with particular emphasis on trainee motivation, training programme quality and subsequent use and embedding of knowledge and skills. In order to evaluate the training programme, a series of questionnaires were devised and administered at specific times during and after training. Reports were also requested from the schools involved to obtain further information regarding the areas of evaluation. The paper offers an overall summary of findings, and makes recommendations regarding future areas of investigation in projects of this nature.

KEYWORDS

music; therapeutic; skill-sharing; schools; motivation to learn; instrumentality; transfer; skills

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INTRODUCTION

The training of musicians and non-musicians in interactive therapeutic music-making by music therapists is now becoming an established practice in parts of the world where access to music therapy is non-existent or severely limited (Margetts, Wallace & Young 2013). This evaluation project concerns such a project designed and delivered by Music as Therapy International (MasTInt) in the West Bank. For the purposes of this evaluation report, it should be stated that the term *interactive therapeutic music-making* describes a music programme where the music group leader engages in joint music-making with their clients. Activities are selected and devised for their potential to reach therapeutic goals selected by the project recipients in tandem with the project organisers and trainers.

MasTInt is a UK-registered charity whose primary activity consists of providing therapeutic music skill-sharing training led by music therapists in such areas. It was set up in 1995 when the first such skill-sharing project took place in Romania. Since 2009, a broader international remit was added to the charity's mission, with projects being initiated in the West Bank, Georgia and Rwanda. In addition to their international portfolio, the charity runs an interactive music-making course in the UK each year. This seeks to train early years' practitioners in using music to support children's learning and development. Many of their international projects take place in areas of ongoing or past conflict. Staff teams in settings such as care homes and schools are equipped with skills and materials to run interactive music programmes addressing the psychological, educational and emotional needs of children. The charity has developed its own six-week training model which allows for a two-person team of a music therapist and assistant (musician or music therapist) to work with local partners and develop a sustainable interactive therapeutic music programme. Importantly, although the charity has worked in a variety of different countries and settings, each programme is bespoke. Detailed discussion of the aims and objectives of local partners before the training begins, as well as a week of observation on-site equip the training team with information regarding which therapeutic activities may be of use, and which therapeutic approach will be fit for purpose. A training programme is then devised on-site, with a resource booklet being prepared for the trainees after the initial six-week stage of the project is over. Staff are then supported by email, online meetings and newsletters once the six-week project has ended. Reports are requested on a six-monthly basis, with the potential for follow-up visits by the original team, other trainers or more local professionals to further develop staff skills.

In the past 15 years, an increasing amount of evidence, mainly focussing on case studies, describes the value of using music therapy in war-torn or conflicted areas. Sutton (2002), amongst others, has edited a book where an interesting overview of work in areas such as Northern Ireland, South Africa, and Bosnia-Herzegovina is provided. Pavlicevic (2002), for example, writes about her work as a music therapist in South Africa. She describes the complexity of living in a society where it is not necessarily the sudden, frightening outburst of a single violent act, but rather the constant rumbling backdrop of conflict to everyday life that is just as traumatic and unsettling. In this context, she writes movingly of a traumatised child being able to summon a sense of self and revivify their inner *Music Child* through music therapy sessions. In the same edition (Sutton 2002), Lang and McInerney (2002) have also written of music therapy work with the organisation War Child in Bosnia-Herzegovina. They report the importance of creating a safe, containing therapeutic environment to facilitate positive outcomes from music therapy sessions. They see the music-making process as vital to clients being able to safely explore and re-experience difficult feelings resulting from traumatic events in their lives. The non-verbal properties of music-making seemed particularly important, as sometimes clients "simply did not have the words to say what was clearly expressed through the non-verbal medium of music" (Lang & McInerney 2002: 172). Equally, Nicholson, (2014), a music therapist working with traumatised clients in Rwanda for *Musicians Without Borders*, sees the value of the individual music therapy sessions he offers. He believes music therapy provides the opportunity to connect non-verbally in the moment, sharing emotional experiences with another creatively and authentically. Another music therapist, Shrubsole (2010) has described her clinical work in post-conflict Uganda, focussing on the importance of shared aspects of culture as well as the impact of a language barrier. She also references the importance for clients of sharing aspects of their emotional experiences non-verbally in a safe therapeutic space.

Although therapists' approaches may differ, the body of work referenced above describes the ability of music therapy to provide a facilitating environment in which traumatic experiences can be safely explored, and damaging patterns of

behaviour addressed. This has led music therapists to infer that these populations can benefit from music therapy.

It is the case, however, that in some of these and other geographical areas, access to music therapy as a form of intervention is severely limited. This lack has given rise to individuals and organisations such as MasTInt offering interactive therapeutic music-making training projects to local staff in response to a perceived need by training recipients. Although some projects offer qualitative evaluative insights on the efficacy of such training programmes, what is still lacking is a systematic evaluation on the extent to which training is transferred and sustained in the long-term (Coombes 2011). In addition, there is a distinct lack of research into the motivations and expectations of trainees themselves and on the extent to which they believe the training programme is relevant and useful for them. Exploring trainees' motivations and expectations has the potential to support sustainability of training (Coombes 2011), particularly as they were found to be consistent predictors of training effectiveness and transfer (Colquitt, LePine & Noe 2000).

Conceptualised as "a specific desire of the trainee to learn the content of the training program" (Noe 1986: 743), motivation to learn has been found to be central to the success of training (Colquitt et al. 2000). Research to date has shown that motivation to learn matters before, during and after training and it should be promoted throughout the learning process (Salas, Tannenbaum, Kraiger & Smith-Jentsch 2012). Within the literature on motivation to learn the construct is conceptualised as either the amount of effort trainees are prepared to put into learning the training materials (Noe 1986), or as a function of Vroom's (1964) expectancy model (Baldwin & Karl 1987; Mathieu, Tannenbaum & Salas 1992). Whilst one approach considers motivation as a way of gauging how trainees view their participation, the other approach highlights the importance of expectancy of outcomes. Within this framework, instrumentality is particularly powerful in predicting training outcomes, as trainees make instrumentality-based calculations when analysing exchanges with the organisation and when thinking about the anticipated consequences of participating in training (Tharenau 2001). More specifically, instrumentality is concerned with job or career related benefits, and pivotal to the decision-making process is the question of what purpose the training will serve and whether this purpose is likely to be met (Chiaburu & Lindsay 2008). This paper seeks to explore aspects of such a training programme, MasTInt's Project Beit Sahour, that was delivered in two schools in the West Bank. It uses data gleaned from questionnaires and reports to examine trainees' motivations to attend the programme and their expectations of the course, as well as the efficacy of the programme itself. The main questions the evaluation was set to address were as follows:

- To what extent are trainees motivated to attend the training programme?
- To what extent do trainees perceive the training programme to be instrumental and beneficial to their work or career?
- How satisfied were trainees with the training programme?

In addition to these questions, an overarching objective of this evaluation was to gauge transfer of skills post-training. With this in mind, data concerning embedding and confidence of using the newly acquired skills and perceived benefits to work practice were gathered and reported in this paper.

It should be mentioned here that we acknowledge the influence of factors such as 'outsider' professionals working in an unfamiliar culture and other aspects of this work in which cultural difference plays a large part. This evaluation has not investigated these areas in any detail, choosing instead to focus on data gathered from the questionnaires and reports. It should be noted, however, that MasTInt projects do take these issues seriously, and endeavour to consider such matters with great care and sensitivity.

BACKGROUND

Project Beit Sahour is located in the West Bank in a small town close to Bethlehem. Due to the prevailing political situation there is a continual threat of military and civilian violence. Regular incursions by the Israeli military and situations that constantly challenge economic, social and educational stability mean the area is in a state of high tension. Teachers and social workers working in this environment face daily challenges associated with stress and anxiety. The schools involved in this project report high levels of students exhibiting acting out behaviour in classrooms and at home.

Some evidence suggests that Palestinian children regard positive school-based experiences and educational achievement as providing the

potential to offer emotional resilience associated with their living conditions (Qouta 2004). Evidence such as this and reports from Project Bethlehem (Coombes 2011) led the schools involved in Project Beit Sahour to contact MasTInt to explore the possibility of such a training project being offered to their staff.

This training programme was a joint initiative between MasTInt and the Evangelical Lutheran Church in the Holy Land (ELCJHL), a German-based Christian organisation which runs three co-educational schools in the West Bank, and one in Jordan.

THE TRAINING CONTEXT

In September 2012 a team of two music therapists travelled to Beit Sahour, a small town in the West Bank adjacent to Bethlehem to deliver the above training programme to staff at two different schools. For the purposes of this paper and to ensure anonymity is respected, they will be referred to as Schools 1 and 2.

School 1 is based in the heart of the old part of Beit Sahour, a town of some 13,000 inhabitants located to the east of Bethlehem. Situated amongst the winding streets, the school is very much a part of the local community. Indeed, it was first established there in 1901. It is co-educational, and typically had a population of approximately 520 pupils at the time of the training, ranging from 4 to 18 years of age. Many of the students' parents also attended this school, and a significant number of the teaching and support staff are also former pupils. It has 30 educators on its staff list. Pupils are 80% of the Christian faith with the remaining 20% being Muslim.

In comparison, School 2 is situated on the outskirts of Bethlehem and Beit Jala, a neighbouring (almost contiguous) town, high up on a hillside. It is a new school, having been established in 2000. It is also co-educational, and had a typical population of 310 pupils at the time of the project with 31 educators in its staff team. The pupil base for this school is drawn from a less homogenous community than that of School 1 with a more evenly balanced mixture of Christian and Muslim families. Some pupils live in the neighbouring refugee camps while others are located in private homes in Beit Jala or Bethlehem.

A total of 10 trainees, 5 from each school, took part in the training programme; 8 being teachers and 2 social workers. The majority of participants volunteered to take part with 3 being chosen to attend by their managers. All trainees but one were females. The teachers worked in different areas within the curriculum. The average age of trainees was 35, with the youngest being 24 and the oldest being 47.

DELIVERY OF THE TRAINING PROGRAMME

Table 1 displays the timeframe of the training programme and of data collection. The first week (Week 1) was a settling-in period for trainers and trainees. This helped trainers identify needs and devise the bespoke training programme. Trainers spent time observing classes and meeting staff. They also ran one experiential music group for staff. In subsequent weeks (Weeks 2-5) the project team ran daily interactive therapeutic music groups of pupils, with each group receiving a weekly session. One trainee would sit in on a designated group, assuming more responsibility for leading the group week by week. Trainees worked with or observed the same groups during this time. Weekly staff group training sessions were also arranged where principles of music therapy were introduced. The final week (Week 6) was a time when trainers prepared the booklet that was left for trainees to use post-training.[1]

EVALUATION METHOD

Evaluative data were gathered by the use of questionnaires and evaluation reports. Three questionnaires were administered in total to each participant and evaluation reports were requested at two different time points post-training. The timeframe in which these were administered is displayed in Table 1. As can be seen, the first questionnaire was administered at the end of the first week of the project. It included measures of demographics (age, gender) and background variables related to the job. It was designed to tap into trainees' perceptions of instrumentality of the training programme and motivation to learn the new material (see Appendix for measures). Each trainee was allocated a unique number that was entered on

[1] To obtain a copy of the booklet which provides an overview of the therapeutic principles applied and activities used, please contact Elizabeth Coombes.

Timeframe of training	Brief Description of Training / Monitoring Process	Data collection
Week 1	Observation of setting, initial musical experiential group, meeting trainees, devising timetable.	Questionnaire 1 administered at end of the week.
Week 2-5	Interactive therapeutic music groups led by trainers with trainees participating. Training workshops held.	No data collection.
Week 6	Trainees lead interactive therapeutic music groups. Final workshops held. Booklet of activities prepared and distributed.	Questionnaire 2 administered at the end of the week.
5 months post-training	No training activity.	Evaluation reports requested from schools.
6 months post-training	No training activity.	Questionnaire 3 administered.
13 months post-training	No training activity.	Evaluation reports requested from schools.

Table 1: Structure of the training programme and data collection

the questionnaire to ensure anonymity of the data and this number was used in subsequent questionnaires. All items asked participants to indicate on a scale from 1 to 5 how much they disagreed or agreed with statements. All questionnaires were collected by the project team or leader.

The second questionnaire was administered at the end of the 6-week training programme. It re-examined instrumentality and motivation and also included measures of satisfaction with training. This was assessed through rating five statements related to satisfaction with the trainer (e.g. *"the trainer gave me specific guidance as to how I could improve"*), and four statements designed to tap into satisfaction with the training materials and methods (e.g. "Taking part in the pupils' music sessions was the most useful part of training").

The third questionnaire was administered six months after the training ended. It focused on the extent to which trainees transferred the newly acquired skills to the job, the usefulness of the booklet provided and whether they felt that the training was useful for managing behaviour and emotions of children in the classroom. Space for qualitative comments was provided throughout the questionnaire to enable trainees to put additional information with regards to their satisfaction of training.

Reports were requested five months and thirteen months post-training, to ascertain whether trainees were running interactive therapeutic music groups, and if so, to explain their aims in using them, and how often they had managed to run them. They were also asked to report a brief case study on a group or an individual and to note any challenges they had experienced. This aspect of Project Beit Sahour is common to all MasTInt projects.

RESULTS

To recap, the purpose of this paper is to report the findings in relation to the motivations and expectations of trainees, as well as their satisfaction with the six-week training programme. In addition, it seeks to report the findings on the extent to which the newly acquired skills were transferred and embedded in everyday practice. Analyses of the evaluation data were therefore conducted in the following way.

ASSESSING MOTIVATION AND SATISFACTION WITH TRAINING

To assess trainees' levels of motivation and perceptions of instrumentality at the start and at the end of the six-week training course, and to ascertain their satisfaction with the programme, the mean scores were calculated for each scale in questionnaire 1 and questionnaire 2 (i.e., Week 1 and Week 6 of the training programme, see Table 1 above). To accomplish this, scores of the four instrumentality items, the three motivation to learn items, the five satisfaction with trainer items, and the four satisfaction with training materials items were added to form an overall score for each participant. Participants' scores were then added in order to calculate a mean score for the group and this score was then compared to the lowest and highest possible score that could be obtained for each scale.

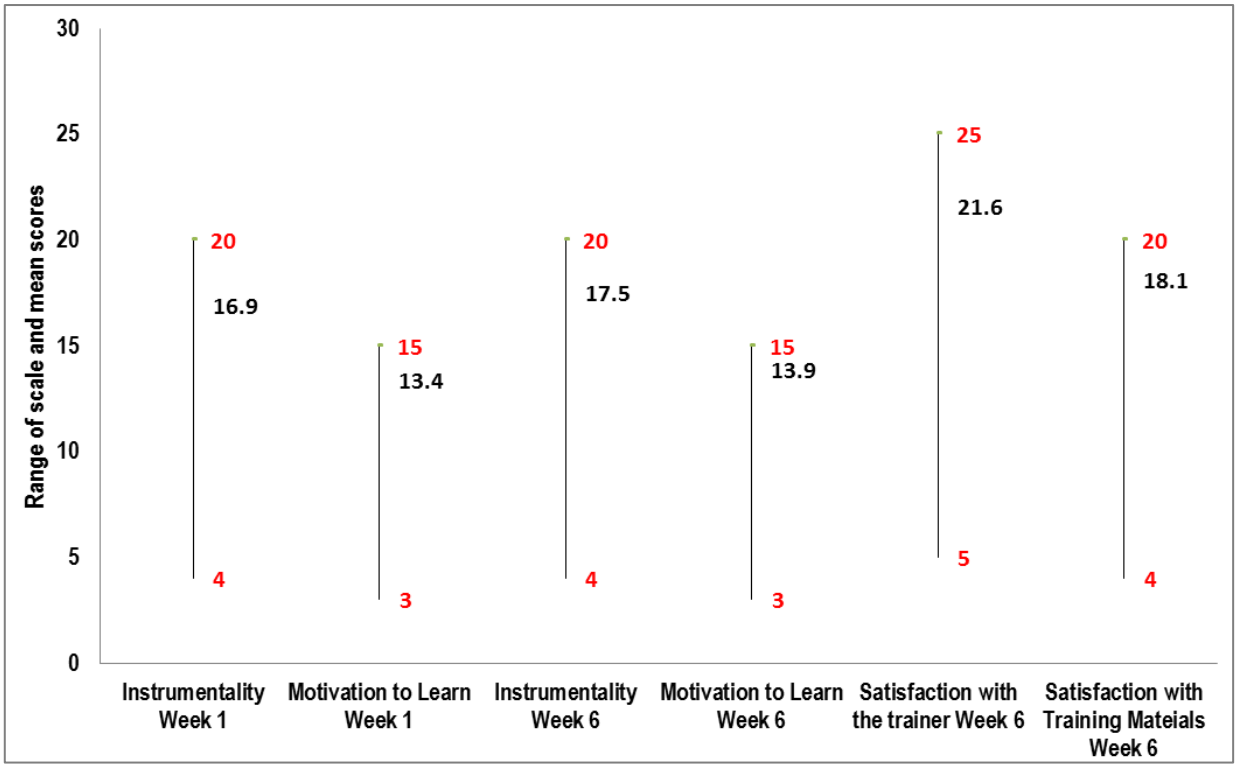

Figure 1: Range and mean scores for instrumentality, motivation to learn, and satisfaction with training

Figure 1 displays the highest possible score and the lowest possible score one could obtain on the instrumentality, motivation to learn, and satisfaction with training scales. It also shows the mean scores for the group. Given that the lowest possible score is 4 and the highest possible score for instrumentality is 20, results suggest that as a group, trainees scored above average on instrumentality at the start of training (Mean = 16.90 at week 1) and also at the end of the training programme (Mean = 17.50 at week 6). Similarly, with the lowest possible score being 3 and the highest possible score for motivation to learn being 15, Figure 1 shows that, as a group, trainees scored above average on motivation to learn at the start and at the end of the training programme (Mean = 13.40, 13.90, week 1 and week 6 respectively). This suggests that, on average, trainees were excited about attending the training course and were prepared to put effort into it, at the start and also at the end of the six-week training period. They also perceived the training to be relevant for their job and that it was likely to provide them with useful skills.

Figure 1 also shows that trainees were highly satisfied with the training course (as measured in week 6). With the lowest possible score of 5 and highest possible score of 25, as a group, trainees scored above average for satisfaction with the trainer (Mean = 21.60). Trainees were also highly satisfied with the training materials. With the lowest possible score of 4 and highest possible score of 20, a mean score of 18.10 suggests that they were satisfied with materials used such as the booklet, and the pupils' music sessions.

Qualitative comments provided by trainees at the start and the end of the six-week training course (questionnaires 1 and 2) reveal that staff from both schools felt they might find the training useful. However, there were some interesting differences between the schools in terms of expectations. Staff from School 1 had pupil-oriented goals such as assisting pupils in lessons and with concentration, while those from School 2 were more self-oriented, hoping to gain new skills. For example, one person hoped to learn how to release their own stress, which was not a primary goal of the programme. The second questionnaire revealed additional differences between the schools. School 1 staff were highly complementary about the trainers, and commented that they could use their newly acquired skills with shy or hyperactive students. In contrast, School 2 staff comments focussed largely on the lack of time trainees had to undertake the training programme and to continue to use it. One person did not feel they would be able to continue to use these skills, while another felt that a teacher wholly dedicated to this work was required. This suggests that although the quantitative data indicate satisfaction with

training, trainees from School 2 may have been more reluctant about the training and the extent to which they can apply it.

ASSESSING TRANSFER OF SKILLS AND SUSTAINABILITY

One of the main objectives of the evaluation was to ascertain the extent to which the training was embedded and used in everyday practice and this was assessed by analysing the answers to questionnaire 3 (six months post-training) and by examining qualitative comments not only in this questionnaire, but also in the two evaluation reports (five months and thirteen months post-training). One of the trainees did not return the third questionnaire and data were therefore available for 9 of the 10 trainees. Figures 2 to 4 offer a summary of the answers provided in questionnaire 3 by trainees.

Figure 2 displays trainees' responses to questions related to confidence and usability of the newly acquired skills six months post-training. As can be seen, all but one trainee felt confident to use the skills and found the booklet to be useful. With regards to usage of interactive therapeutic music groups, five of the trainees either agreed or strongly agreed that they use the skills on a weekly basis.

In Figure 3, trainees' answers to questions relating to how helpful the training was for them in the management of children's emotions in groups and in the classroom are reported. As can be seen, all but one trainee either agreed or strongly agreed that as a result of the training course they felt better able to respond to children's emotions. They were less certain of the extent to which children participating in interactive therapeutic music groups are better at managing their emotions.

In Figure 4, trainees' answers to questions relating to how helpful the training was for them in the management of children's behaviour in groups and in the classroom are reported. As can be seen, all but one trainee either agreed or strongly agreed that as a result of the training course they felt better able to respond to children's behaviour. Again, they were less certain of the extent to which children participating in interactive therapeutic music groups are better able to manage their behaviour.

The qualitative comments noted by trainees in questionnaire 3 (see Table 2) and in the evaluation reports provide examples as to practical activities and how the skills acquired during the training programme were used in everyday practice. Interestingly, staff from School 1 offered almost twice the number of comments as those elicited from School 2. There were many positive comments from School 1 trainees, including those relating to feeling upskilled, feeling able to transfer skills from small groups into whole classes and seeing a difference in pupils' confidence. One person reported being able to use elements of the training at home with their own children. School 2 trainees, in contrast, mainly provided comments on their satisfaction with training, but less about the extent they used it in their work. As can be seen in Table 2, they mentioned issues such as a suitable room being needed, the programme needing a structure and a dedicated timetable, and only one comment was made about usability, stating that they could use some activities in whole classes.

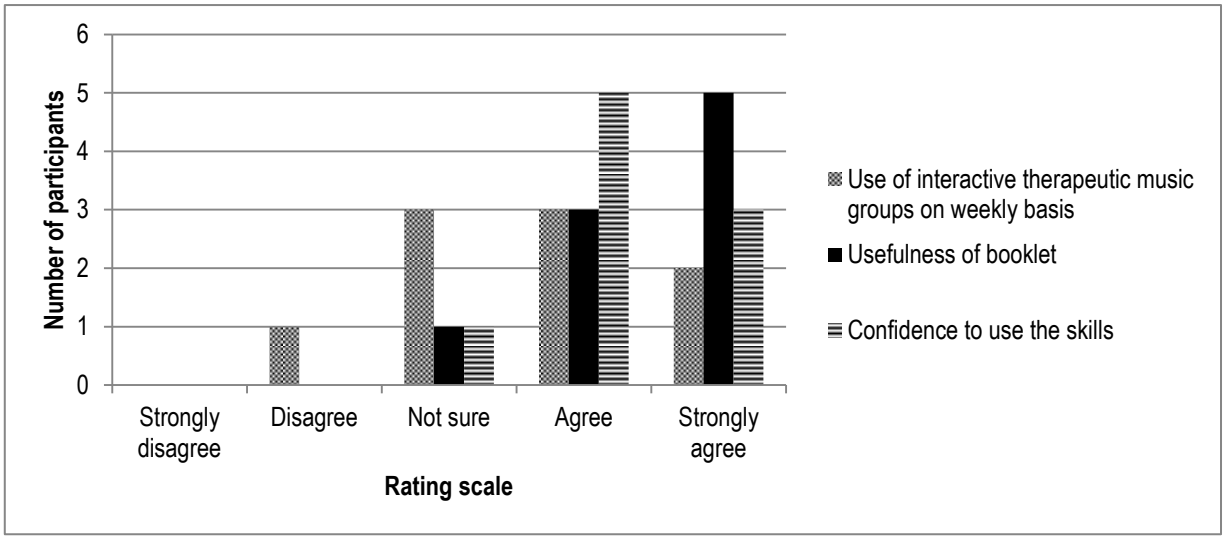

Figure 2: Participants' reporting of confidence to use the new skills, usage of skills, and usefulness of booklet post-training

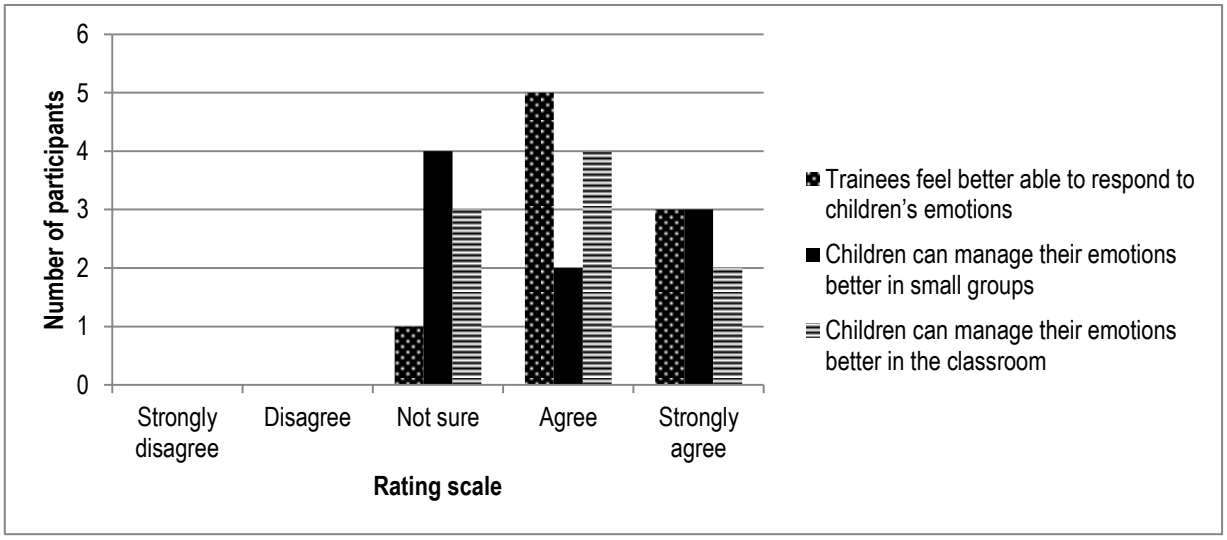

Figure 3: Participants' reporting of how helpful the training was for them in management of childrens' emotions

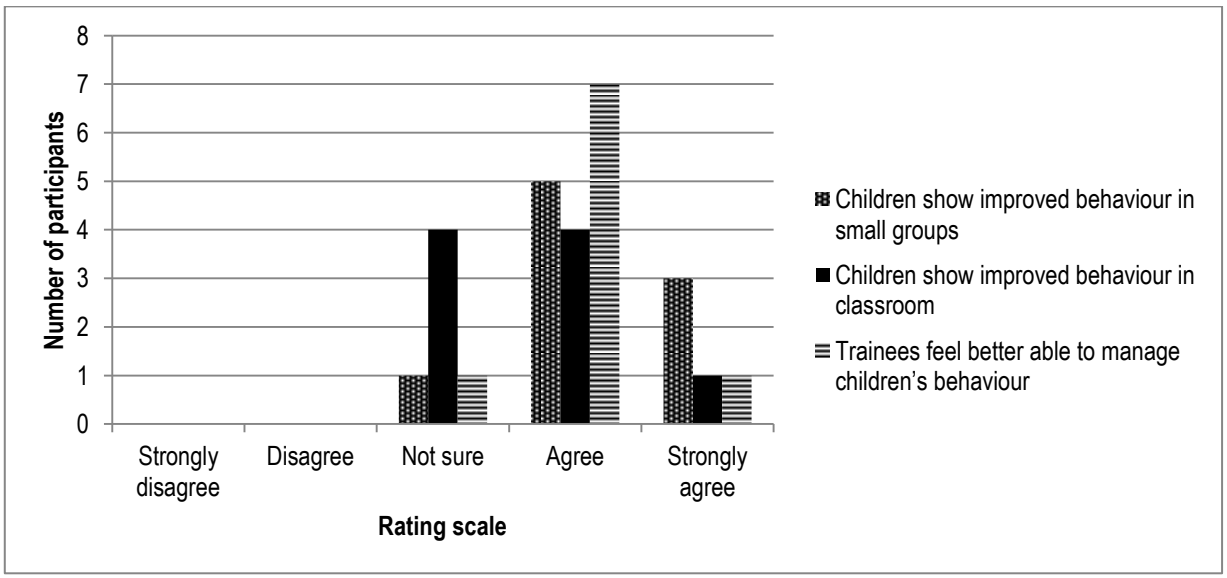

Figure 4: Participants' reporting of how using the newly acquired skills helped improve children's' behaviour

School 1:
• We are limited in time so we must plan the program carefully • Encouraged students' confidence • Helped generally with younger children • Concentration • Instead of everyone doing the same thing at the same time, there were many different things going on in the group. This made it different from anything else they had experienced. They could show themselves at their best here even if they were weak in other subjects • I now have more ability to control hyperactive students • New skill to do job in a better way • I realised it was better to have the hyperactive children and the shy children in different groups. They improved more in this way • It helped me at home with my small children • I used musical activities with whole classes • Used to refocus children during lessons, e.g. making music with pens, etc. • Used techniques to change the mood in classes
School 2:
• The programme needs structure and organisation • It needs a dedicated teacher • It needs a special time of day • We need a special room for the music as therapy groups • Experiential groups were good to release stress personally • It helped me in my work/hobby as singer/musician • I use it in class activities, calming down students • I expected the course would be hard but I found it easy

Table 2: Comments provided by trainees reflecting transfer of skill six months post-training (questionnaire 3)

Evaluation reports; Five months post-training

School 1

To summarise the report, it stated that the children enjoyed these sessions and were eager to have more. The staff had discovered some pupils had musical talent, and also that their ability to stay on task in the music groups and classes increased. The team talked about the pupils developing their own ways of playing the instruments. One person stated:

> "We think that the students' behaviour has changed because the music really is a wonderful way to interact with the students".

Some of the challenges were also indicated; these included how a number of pupils needed a lot of time to settle in the groups; in addition, other school activities meant it was sometimes difficult to hold groups regularly.

School 2

In this report, some of the original teachers had facilitated a few groups. The report stated that:

> "The students' behaviour is improving within the groups compared to how they were behaving within their classrooms".

Staff do say, however, that they are struggling with timetabling and with children missing lessons.

Evaluation reports: Thirteen months post-training

School 1

The reports received in December continued to indicate positive outcomes, although again timetabling remained an issue. This time, extra aims were added into the programme by staff, including "to encourage the pupils" and "to develop mutual respect and broaden their horizons". One teacher devised an activity where they themselves would "make a mistake" so the pupils could correct them. Another new game was to "show the pupils how it feels when they are noisy and don't listen", leading to a discussion about the teachers' emotions. All teachers in the school felt that those involved in the groups showed improved behaviour and engagement. The social worker was also about to commence individual work with one pupil with a view to helping him join an interactive therapeutic music group. One teacher in the programme had left the school, but the social worker was training the new special needs teacher to take her place. In addition to this, a long-term volunteer was being given skills to assist with the groups and potentially facilitate one himself.

School 2

By this time, one of the major challenges for School 2 appeared to have been overcome: a dedicated room for the therapeutic music-making groups. Teachers no longer run any of the interactive therapeutic music groups; these are wholly managed by the social worker. Instruments are stored in the therapeutic music room and used only for these sessions. The report states that pupils are developing their joint music-making through rhythmic cooperation, and this is helping to create a safe space to talk about feelings, to wait their turn and "relieve some creative energy using music as the model". The school believes pupils are learning healthy ways to cope with negative feelings. In School 2, some aspects of the group sessions are devoted to non-musical activities so the tool is not solely music.

DISCUSSION

The purpose of this evaluation was to investigate trainees' motivations to attend the Beit Sahour training programme and the extent to which the training programme met its objectives in upskilling trainees with sustainable tools they can use in the educational setting. To this end, results suggest that all trainees felt the training could be useful to them and were highly motivated to attend, and all indicated that the training had been of a high standard. Understanding the motivations and expectations of trainees proved useful in gauging the efficacy of the training. More specifically, the finding which indicated that motivation and instrumentality remained constant at the start and end of the six-week training programme is testament to the efficacy of the course. Variables, however, are highly malleable and tend to fluctuate as a result of experiences (Tombs 2013). Motivation and instrumentality tend to decrease when trainees are dissatisfied with the training programme; this was not the case here. Satisfaction was indeed high amongst trainees, with all agreeing that the training methods, the materials and the trainers were of a high standard. Thus, considering motivations and expectations as an outcome of training may be more powerful in assessing efficacy than only asking trainees to report their satisfaction. Motivations and good training experiences were therefore a feature of the data gathered, which are the bedrocks for sustainability and efficacy of training (Bhatti et al. 2014).

One of the key advantages of the current evaluation study is the gathering of data at different points in time post-training, enabling examination of actual transfer and sustainability of new knowledge and skills. Qualitative comments provided in the post-training questionnaires and the evaluation reports indicated that some trainees seemed able to use the skills and training in a wider context than simply running interactive therapeutic music groups. They stated that they were using musical activities with whole classes, sometimes to refocus their pupils. Although this was not a primary goal of the training programme, it is an interesting finding and one that has the potential to broaden the remit of further training opportunities. It appears the training had given staff a different perspective on their roles in the school and, possibly, more confidence generally in their work. The reports, especially those from School 1, seem to support this, with staff stating they had made new discoveries about their pupils because they were working with them using music. There are also interesting comments made regarding staff developing and devising their own activities; this appears to show that the skills transferred are being applied in ways that fit the context. It may be argued, therefore, that rather than slavishly following the format demonstrated by trainers of small, interactive therapeutic music groups, skills are being generalised into the teaching programme of the school as well as being preserved in the small group format. Staff felt able to use their new skills in a wider context than simply small groups, demonstrating that transferability of skills is occurring. To this end, findings support previous literature on the usefulness of music in the management of behaviour in the classroom (Derrington 2011; Sutton 2002). It is important to note that no in-depth analysis of which particular activities or general therapeutic principles were considered most useful was undertaken in this evaluation. This might have been useful as it could have enabled any future training input to build on those aspects considered of greatest value to these particular settings. It would also have been helpful for the evaluators to have had clearer information regarding the workshop elements of the training programme. Documentation relating to precise teaching methods, including materials used, may have enabled a fuller examination of the efficacy of the methods deployed to impart technical knowledge.

An interesting finding emerged from the data which indicated that the two schools differed in terms of trainees' reporting on the usage of skills. More specifically, whereas trainees from School 1

provided rich comments about usage of skills, trainees from School 2 mainly focussed on resources and barriers to run the groups. The School 1 team reported that the training had helped them generally in their work. They also made other observations, such as the small groups being a place where "there were many different things going on in the group" which was a new experience for pupils who would normally expect to all be doing the same thing. It was also noted that the pupils "could show themselves at their best here even if they were weak in other subjects". Such comments showed more insight into pupils' needs and a more obvious development in the way the groups were being operated. It was also noted that School 1 were endeavouring to keep a larger team using these skills, and to maintain music as the only tool used in the groups. In contrast, School 2 only have one member of staff using interactive therapeutic music groups meaning that the programme would not be sustainable if this staff member were to leave or to cease running the groups. Comments from staff at School 2 reveal concerns regarding practicalities of running groups, with suggestions made such as a specific teacher being needed to undertake this work.

Given that trainees from both schools were highly motivated to learn and could see the benefits of attending the course, other factors may have played a part in leading to these differences. For example, within the literature on training in organisations, evidence now exists on the impact of the environment in which trainees work on the transfer of training (Bhatti et al. 2014). Many factors work against employees effectively transferring the new skills, particularly lack of support and opportunities provided by line managers and colleagues. At the time the project was delivered, aspects of organisational dynamics or environmental factors that may have played a role in the embedding of skills were not explored. Future projects could possibly consider gathering more information regarding the environment, staffing levels and management structure of the schools to give clear parameters as to what staff resources may be needed to embed the training into everyday practice in other projects.

Some limitations must be noted before drawing conclusions from this evaluation report. To begin with, it may be argued that findings are limited by the use of a small sample size. However, this sample size is typical of MasTInt training programmes. In addition, there is the potential for insider research and evaluation to compromise validity (Kvale 1995), though there are also complex arguments for the usefulness of such work. Reed and Proctor (1995) identify various criteria relating to practitioner research in healthcare settings that can be generalised to insider-researchers in other settings. They state that such research may be focussed on aspects of practice in which the researcher has a high degree of involvement and therefore there is potential for changes in working practice to be effected as a result of the findings of the research. The voices of the participants hold great importance in such work; the relationship of the insider to the participants may in fact enable a higher degree of freedom and authenticity to be present in the data gathered. Others also suggest that insiders have access to a wealth of knowledge that can enrich and enhance the understanding of the data (Tedlock 2013).

Transfer and sustainability of skills were assessed by using self-report questionnaires. The limitation of such a method is well-documented in the literature (Coolican 2009) and future evaluation projects may add value by employing a multi-method approach. This may include obtaining reports from colleagues, line managers, and even the pupils themselves. Others may suggest conducting observational studies to observe daily activities of trainees. Evaluation of similar projects, in addition to continuing to monitor Project Beit Sahour, could be widened by using semi-structured interviews with staff to inform future input; not solely from MasTInt but also from other locally based professionals. Tierney (1996) argues that such interviews could add a richness to the data collected and an authenticity that could inform the support and development of this work. Though these techniques are powerful, they are extremely time-consuming and have ethical implications. For the purpose of this project, the most suitable technique for the participating schools and MasTInt had to be deployed.

Consideration should also be given to linguistic differences that may have affected the answers provided by trainees. The first two questionnaires were administered in English, and it was unclear as to how much of the questionnaire was fully understood. The final questionnaire was translated into Arabic, with the results being translated back into English once the questionnaires were returned. As the final questionnaire required more qualitative responses it was deemed appropriate to use Arabic, as staff may have felt more comfortable writing in their native language. It may be argued, therefore, that administering all questionnaires in Arabic might have given more qualitative answers and therefore provided a richer source of data.

SUMMARY

Despite some study limitations, this evaluation has been able to meet its aims of examining the quality and efficacy of the training programme and to assess transfer of skills. The evaluation report of the training programme has given valuable insights into issues to be carefully considered when offering an interactive therapeutic music skill-sharing programme as outlined above. Whilst findings suggest that trainees were motivated and satisfied with training, post-training evaluation highlighted that transfer of skills was dependent on availability of resources and support post-training. One school maintained and used the skills more than the other and some possible explanations for this are offered. Future projects of this nature should consider the environment in which trainees work and the extent to which it will enable the use of skills in the long-term. In addition, future projects will benefit from an in-depth examination of the actual training to ascertain whether issues of transfer and sustainability may be associated with the delivery of training itself. Although the booklet provided some information in relation to this, no information was obtained regarding content of training sessions or workshop plans. This, together with data regarding use of specific activities by trainees, and data concerning which theoretical concepts trainees deemed most useful, may have given evaluators added insight as to whether the training could have been further refined to maximise relevance to each specific environment. Further evaluative work of this nature is required in order to fully understand the conditions and factors that can be leveraged during and after the training programme to improve transfer and sustainability of training.

Acknowledgements

The authors would like to thank Music as Therapy International (MasTInt) and the Evangelical Lutheran Church in Jordan and the Holy Land (ELCJHL) for their support of the project. They also gratefully acknowledge research funding for the study from the Centre of Excellence in Learning and Teaching (CELT) at the University of South Wales. We would also like to thank other members of the research team who assisted in the collection of data, namely: Hazel Child, Teleri Dyer, Naomi Rowe and Eleni Tsolka.

APPENDIX

Items comprising the measure of motivation to learn

1. I am excited to have the opportunity to learn new skills.
2. I will try and learn as much as I can during this training.
3. I am motivated to learn the material during the training.

Items comprising the measure of instrumentality

1. This training will teach me how to work more effectively in my job.
2. I will learn new skills that will improve my general skill level.
3. This training will help me approach my work in a different way.
4. I do not understand how this training will help me work more effectively (Reversed).

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Resilience and Hopefulness

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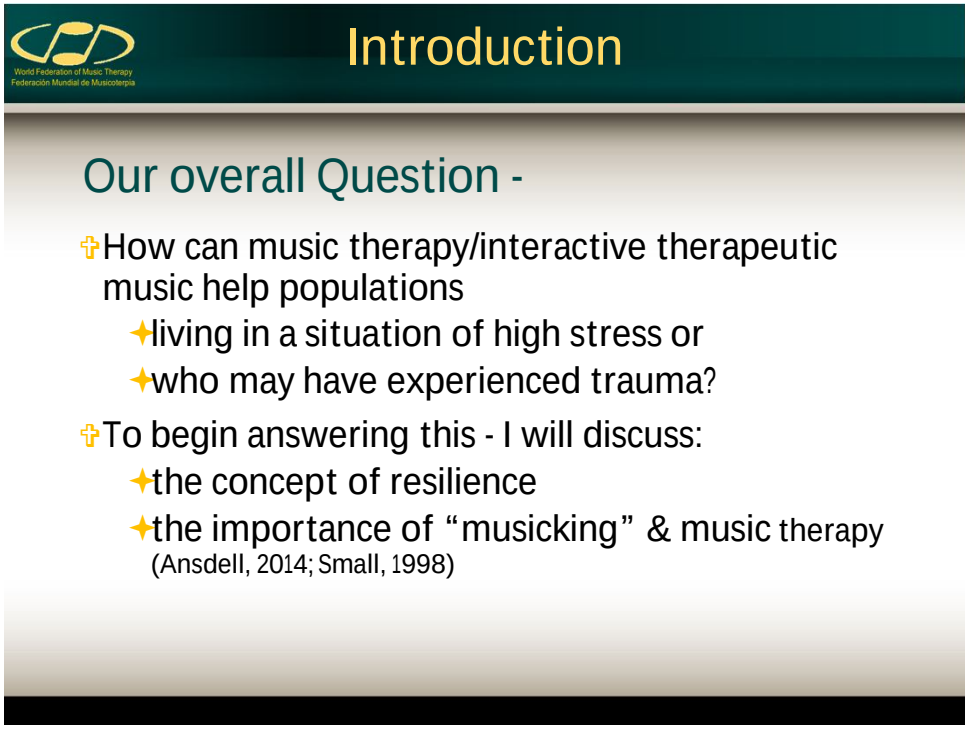
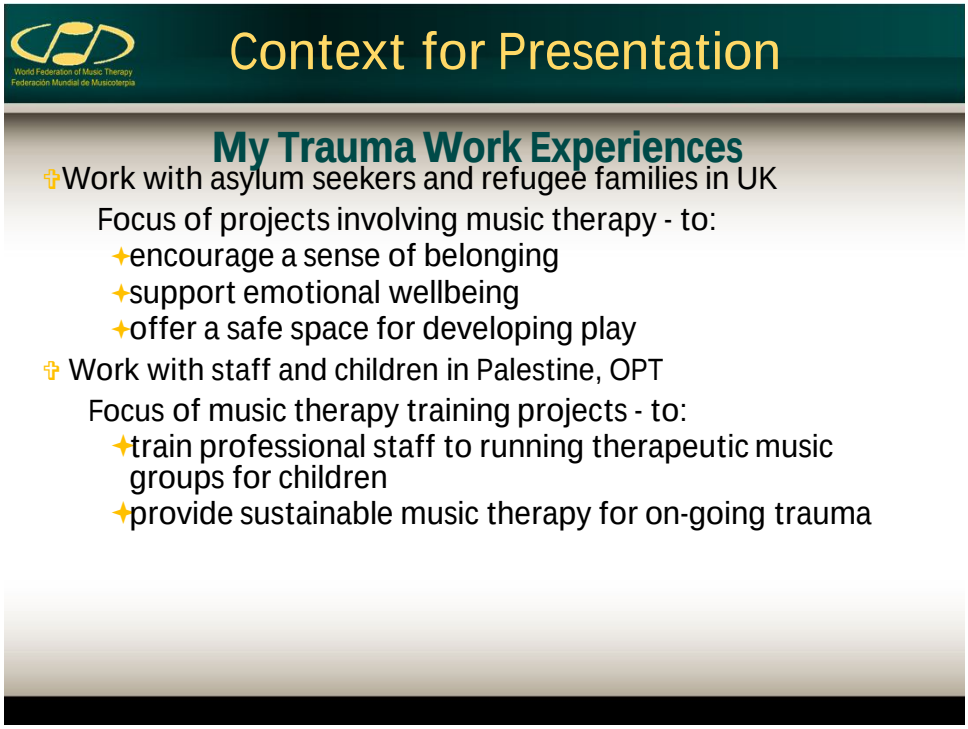
WFMT – SPOTLIGHT SESSIONS
presents

World Federation of Music Therapy
Federación Mundial de Musicoterapia

The 15th World Congress of Music Therapy



To round off this spotlight session I propose to share some thoughts on the topics of resilience and hopefulness, referencing the ideas of musicking in music therapy. I feel these ideas are particularly relevant to this spotlight panel. Indeed, my colleagues have themselves referenced them in their presentations. I intend to link these ideas to clinical work and training projects I have undertaken with populations who have experienced traumatic life events or who live in a situation with consistently high stress levels and unpredictable fast changing and sometimes life threatening situations. The work I am going to talk about is group work that I have facilitated to have enabled others to facilitate. Before I explore the above ideas of resilience and hopefulness some more information about the contexts I am referencing may be of use.



The first context is music therapy work for asylum seeker families and pre-school children in cities in S Wales, UK that I have devised and facilitated. This work has been undertaken with a large UK children's charity with designated centres and projects in many parts of the UK. I worked with the support of a charity worker specialising in supporting families with young children. The families who access the music tehrapy come from a variety of countries such as Pakistan, Syria and Albania, Nigeria and China. Their journey to the UK after having to leave the place of their birth has often been traumatic and difficult. They are newly arrived in the cities and often have a very limited support network on which to draw. The music therapy goals for these families are:
To support emotional wellbeing and inspire hope for the future
To provide a sense of belonging in their new homes and communities
To provide a safe space for play for the children as they begin nursery school
The second context is therapeutic music training for teachers and healthcare working in Palestine. I don't have time here to explain the difficult living circumstances of the Palestinians, but some of you may have a sense of this. For many Palestinians living in the West Bank in the Occupied Palestinian Territories, there is limited access to educational and training opportunities. Their socio-economic status I precarious, and the political situation impacts Heavily on their lives. Since 2009 I have been involved with delivering training and supervising projects in schools, refugee centres and orphanages in the area around Bethlehem. Imparting a range of therapeutic music skills to those

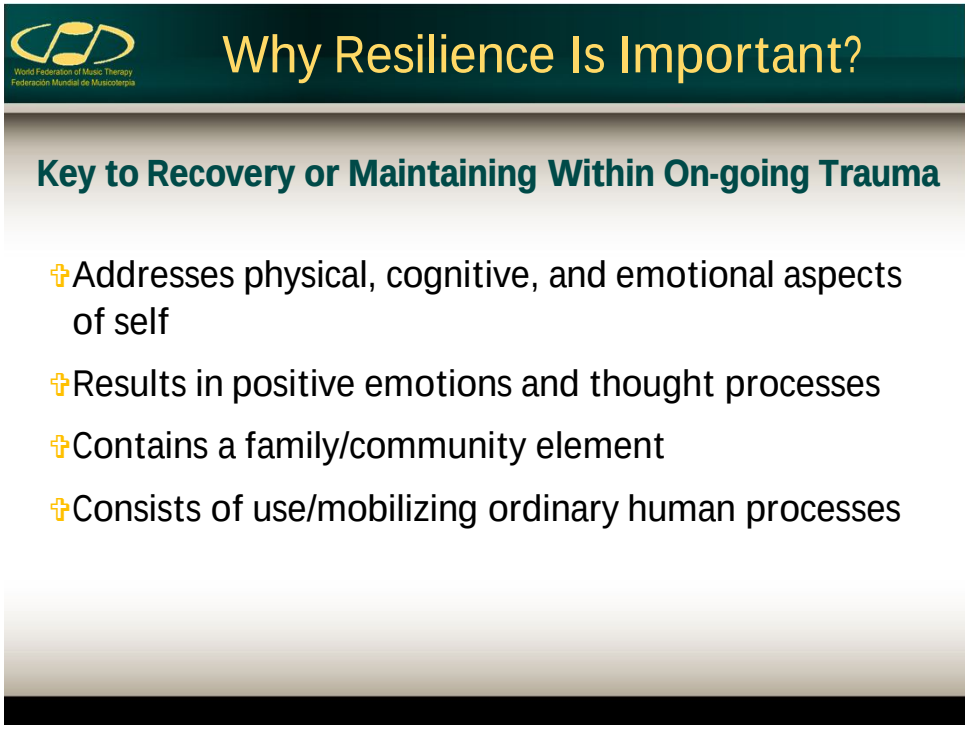
working with children and young people enables teachers and social workers to offer a tailored musical programme to those in their care. The idea has always been to embed a self-supporting therapeutic music program run by Palestinians. Indeed, Beit-Sahour, one of the projects initiated by Music as Therapy International is an excellent example of just this./ You can read about the perceptions of staff delivering the programme in an article by myself and an occupational psychologist in the music therapy journal Approaches. Goals for the children in these programmes are similar to those above: to develop emotional wellbeing, to be able to self-regulate their emotions and to build a sense of community.

What is resilience?

Various definitions of resilience:

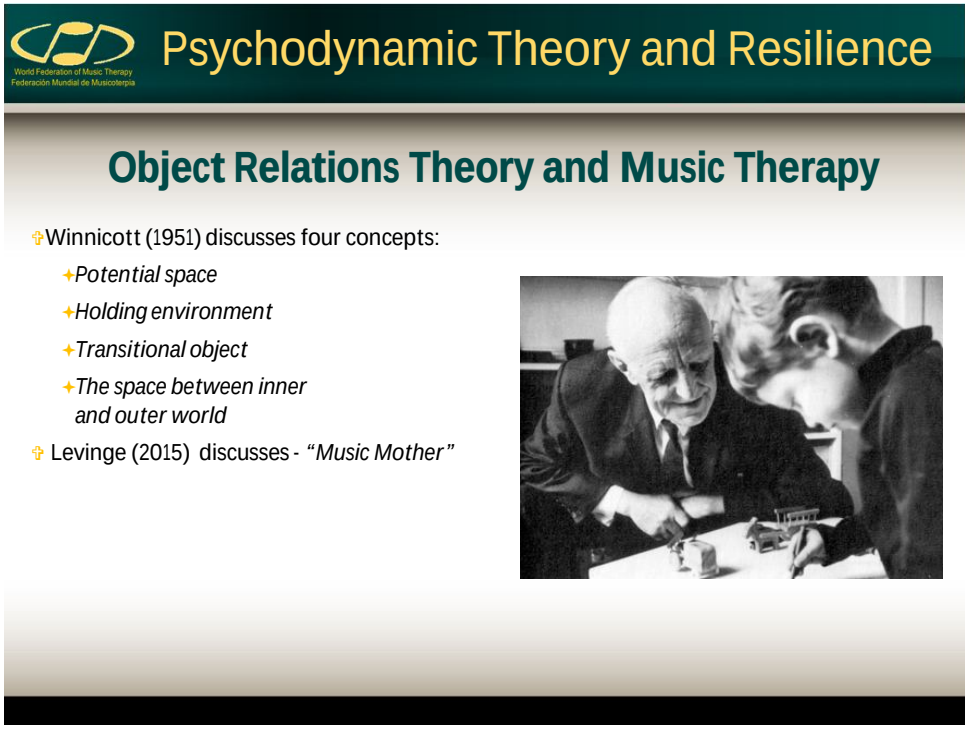
- Ability to adapt in adverse conditions, such as traumatic events
- Flexibility in response to changing situational demands (Tugade, et al, 2004)
- Capacity to mobilize personal features – to prevent, tolerate, overcome, and be enhanced by adverse events (Mowbray, 2010)

Before demonstrating how resilience can be developed using music I want to briefly offer some thoughts on this concept. IN order to be resilient, one must be able to adapt. If we think of Charles Darwin' theories of evolution, then adaptation is key to survival. Humans are highly adaptable, and this skill, which ensures we have, as Tugade says, flexibility in response to changing situations, facilitates resilience. Rather than seeing potentially traumatic events in a negative way, the resilient personl may be able to see them as a challenge that can be overcome using their own personal and social resources.

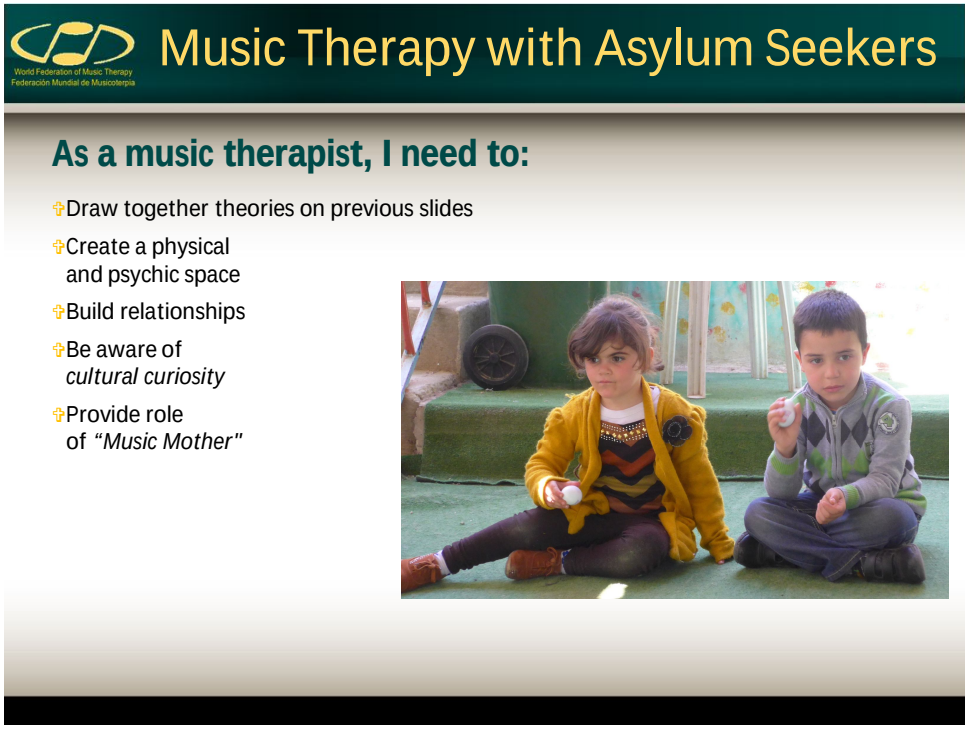


As my colleagues have already mentioned of high importance to the development of resilience is work on the self, a fostering of positive emotions and processes, an understanding of the importance of community and family – in short the group plays an important part in fostering resilience. Looking at the physical, emotional and cognitive parts of the self also seems to really be in tune with the many possibilities music making offer which brings me to my next slide.

So far so good, but why is music therapy/music-making so important in supporting the development of resilience?
Andsell posits that musicality is a core human capacity. He believes we have a natural relationship with music that enables us to develop musicianship in a broad sense. This leads us to the writings of Christopher Small. Small talks about music being an activity not a thin. He imputes a more dynamic sense of the word than that of just a noun. IN his eyes, the verb – to music – takes on a broader meaning. We music together, as indeed we are doing at this conference. Musicking is a way that we respond to the rest of the world, actively not passively. This means that relationship between those that music model real world relationships and provide opportunities for exploration and discovery of the self and others and the worlds itself through the medium of music. Pasiali has written widely on the potential for music and music therapy to offer strategies that rather than treating the results of exposure to traumatic events offer proactive musical approaches to achieve powerful preventative outcomes. In practical terms boundaried or structured musical experiences have the potential to act as supporters of the development of resilience.



For me personally as a community musician then trained in psychodynamic music therapy, the theories of Winnicott offer a helpful underpinning to my work in these contexts. Winnicott is, I am sure, known to most of you, for his ground-breaking work with children and the development of object relations theories. His words, ' it is in playing and only in playing that that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self', to my mind perfectly underpins the ideas behind the work I am doing here. The 4 concepts mentioned above, as well as the music therapist Alison Levinge's ideas of the music mother have supported my thinking and the developing of a practice that I believe offer support in the 2 clinical areas I mention.



In short, drawing together these theories gives me a sold and secure base from which to work while being respectful of cultural and social difference. This is where I must also adapt to offer resilient mode of practice. I think about a physical and psychic space am mindful of cultural difference and maintain an open and curious stance.

Effectiveness of Music Therapy

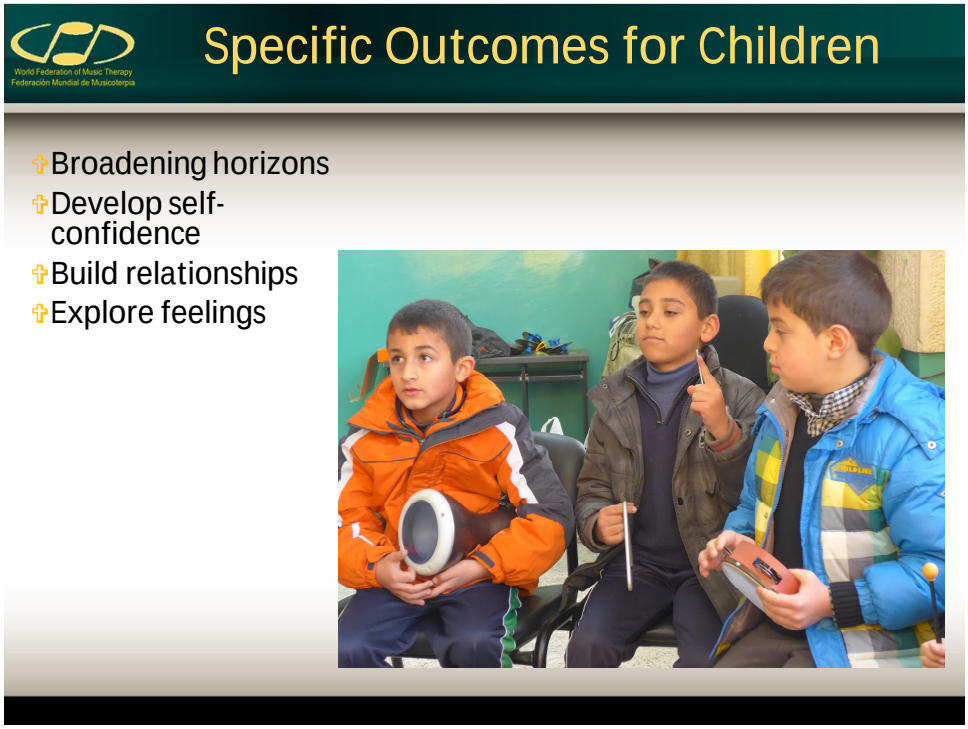
- Challenges to providing music therapy-
  - Attachment issues
  - Disrupted early relationships (Gratier, Apter-Danon)
- Strengths to build on -
  - Adaptation
  - Family bonds
  - Music Therapy bonds

Outcomes of Music Therapy

- Friendships among group members increased outside sessions
- Increased ability to use community resources, public transport, parks
- Members shared "musical cultures" through rhythms and dance moves
- Children more able to self-regulate
- "I begin to feel this place can be my home"

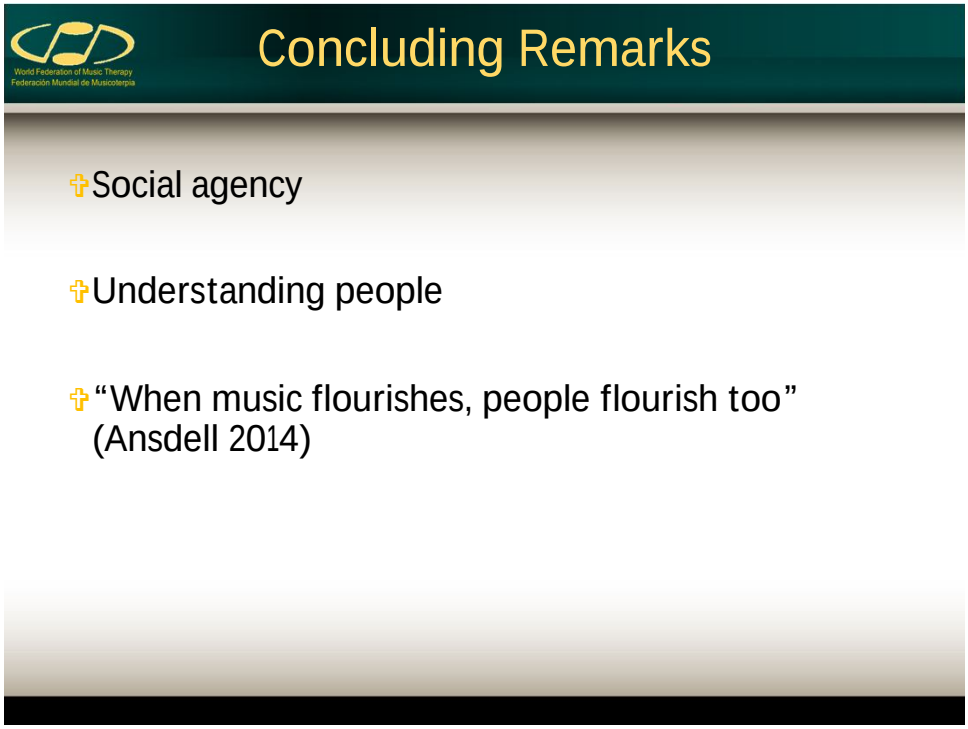
Training projects in Palestine under the auspices of Music as Therapy International and Musicians Without Borders offer an alternative method of support that teachers and socails workers can invoke. A range of simple musical activities that can be adapted by staff to fit their practice and circumstances are taught. Listening and responding, leading and following, exploring different musical dynamics and timbres, using voice and body percussion as well as simple instruments offer multiple ways of relating and developing emotional stability and regulation in a group setting. The theories of Daniel Stern seem to be easily communicated with film and roleplay and these offer ways that trainees can grasp the essence of musicality we all hold and that is key to musicking theapetuically

Staff in these projects report feeling upskilled. The techniques they learned and then developed to fit their needs and culture helped not only in work but also at home and with family. The 3 social workers here in this picture, Samar, Rana and Mary have acquired the expertise to train other staff members and long-term volunteers to ensure the therapeutic music programmes have a wider staff team that can deliver work. Their project, carried our in 3 school in Bethlehem, Beit Sahour and Ramallah here is now complete self-supporting as I cheer on from the sidelines and periodically offer supervision to ensure their practice remains relevant and fresh.

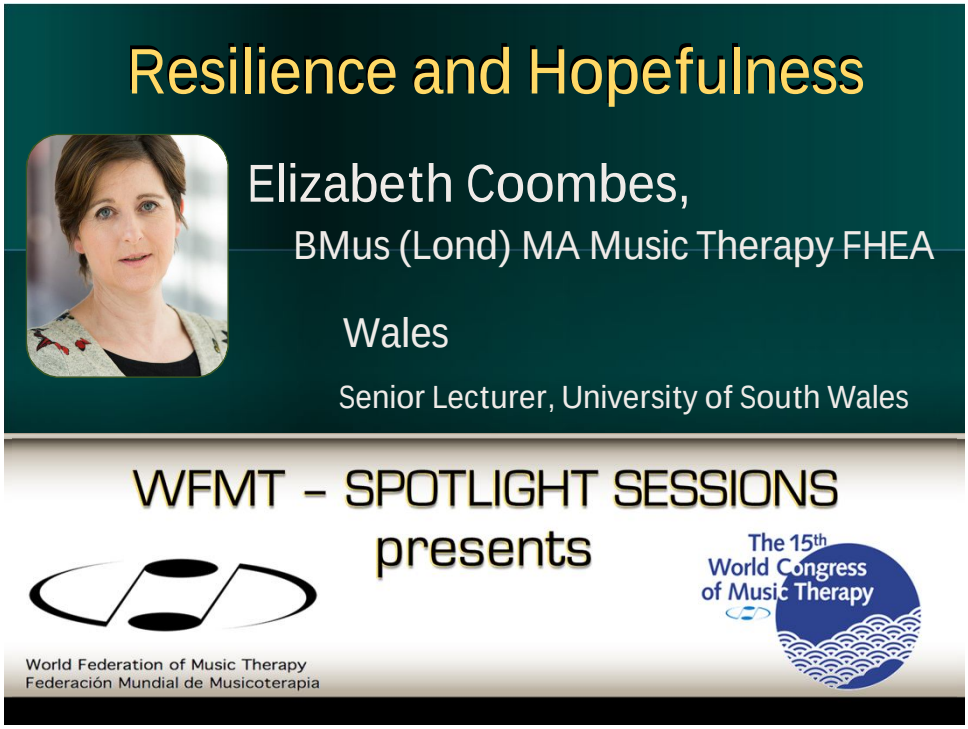


Outcomes for the children in these schools are more positive peer group relationships and improved attitudes towards school. Issues relating to bullying have been addressed through the music groups, with inclusive practice involving children with special needs and those without fostering acceptance and understanding of difference. In Palestine, it seems particularly important that a strong sense of community is developed to counter tensions and splitting that everyday circumstances in which Palestinians live do not spill over ins a destructive way into the school. Here they can learn how to manage these feelings by musicking together. Mary, one of the social workers delivering therapeutic music sessions wrote to share this story with me:
I want to talk about a second grads student called Nyla (not her real name). I chose her last year when she was a first grade student because her teachers and I noticed that she acts differently than her peers. She likes cutting her hair and sometimes her classmates' hair. She physically hurts them and she is very loud and disruptive on many occasions. Nyla doesn't obey the school rules as well. This year, all of the teachers a re glad to admit that Nyla is less violent, respects the school rules and has made great progress in her school work. I believe most of this is due to the music therapy sessions in addition to the support of teachers in class as well as our individual sessions. I am positive that in the future this program will result in more progress and have success stories with more students.
What a great story! I believe this shows how the children are able to feel a

sense of belonging in the small music groups and to feel part of the larger social group of the school and also community. Exploring and experimenting with relationships in music enables a development of their own personal qualities and increases self worth. n fact, staff tell me places in the groups are now coveted with many children who have not been referred into the groups asking to take part. Parents who were worries children would be missing out on important academic work are now asking for then to have a place in the groups also. This is very exciting indeed.



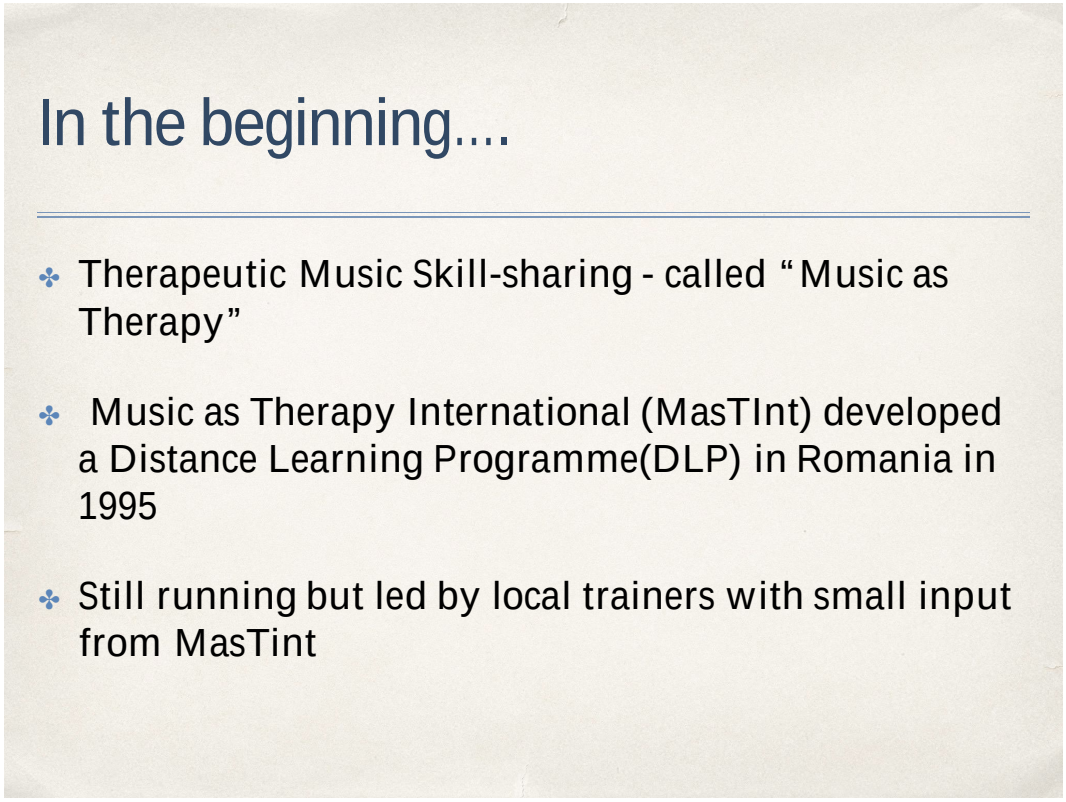
Music therapy and musicking for these 2 populations have given them a sense of social agency , tools that they themselves can use to effect change. Creative possibilities can be safely explored through music. The importance of boundaries, empathy and mindfulness are qualities that families and staff teams have referenced in their own ways as having developed though the use of music. As Andsell says, when music flourishes, people flourish too.



Thank you. I am delighted to be a part of this World Congress. Today I shall provide a brief overview of the disaster preparedness, response, and recovery program at the American Music Therapy Association.

Today I'm going to talk about the development of a Therapeutic Music Skillsharing Blended Learning Programme in Palestine that is taking place in a partnership between Musicians Without Borders and Music as Therapy International. MWB works around the world to build sustainable music programs encompassing performing, training of local staff and

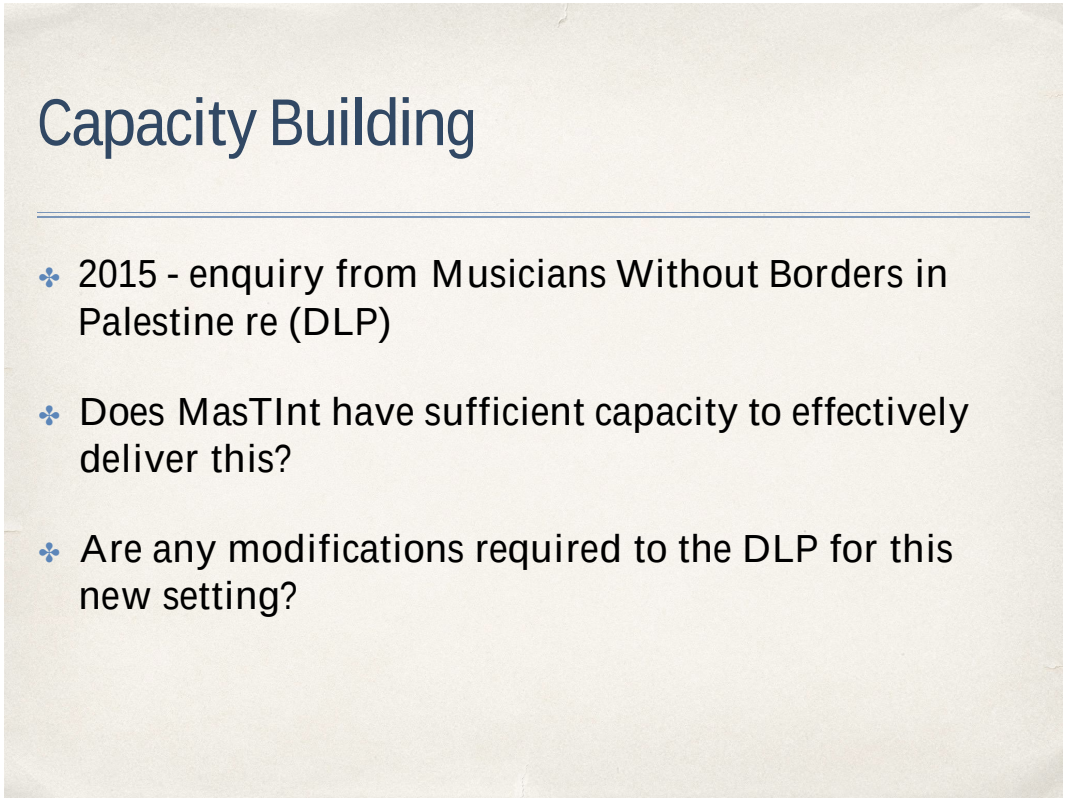
therapeutic support. MasTInt is a UK based charity that delivers therapeutic music skillsharing programmes of varying kinds in a variety of geographical locations including Georgia, Rwanda and Myanmar as well as in the UK. During this presentation, I'll touch on cultural considerations and how an existing training programme had to be adapted for use in Palestine.



MasT came into being in 1995 when its founder Alexia Quin set the charity up in response to an identified need for training in therapeutic music skills in Romania. The idea was to develop a Distance Learning Programme that would support educators and healthcare workers in to music therapeutically with young children in their care.It was necessary for

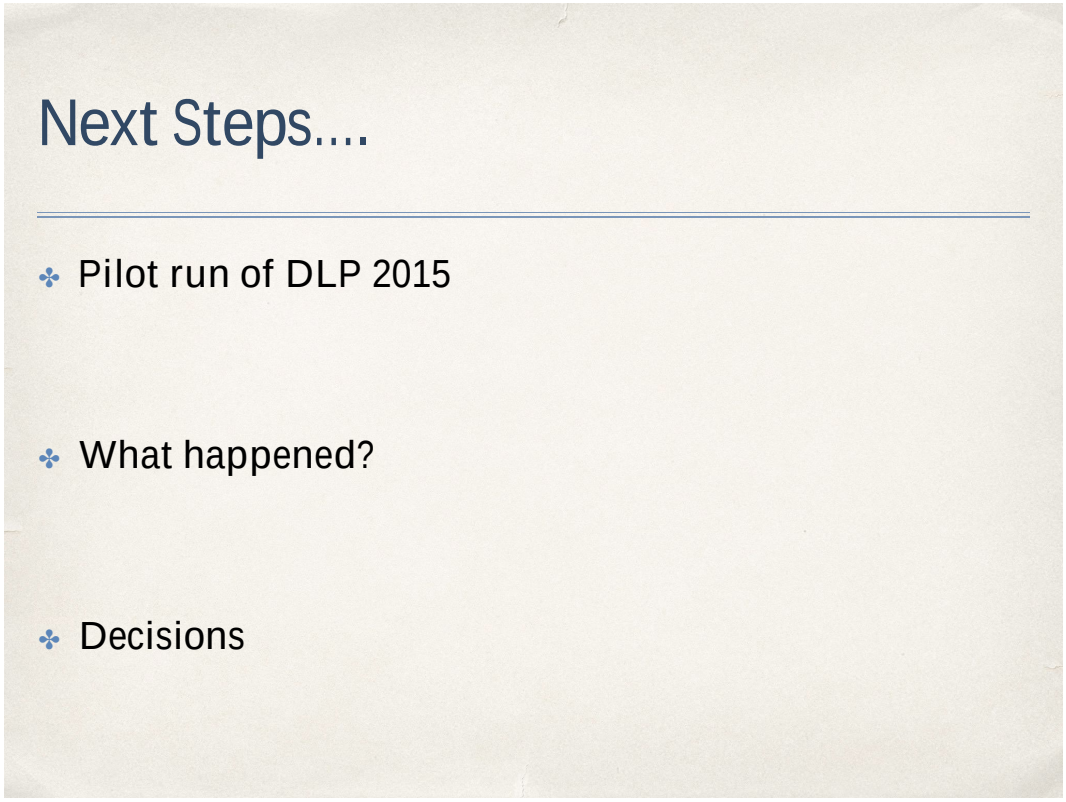
students to be musicians or have any musical experience. Generally the training was offered to staff working with children under the age of 10 with learning disabilities. Please note that in the UK the term LD refers to a ‘significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood’. This definition comes from a UK government website. The BLP consists of a series of online monthly tutorials spread over 8 months with written directed tudy. After the first 2 tutorials there is an Intendive Study Weekend with input form 2 music therapist selected by the charity. These usually come from the UK. The assignments are

marked and returned to students. There is a practicum of 8 weeks at the end of the tutorials with written reports prepared by the students and supervision given by the training team. Students are given training booklets with activities but are also encouraged to use their own ideas. Alexia has significant experience in Romania and speaks the language fluently. This aided her in working with local partners to ensure the programme was relevant ot eh work students were undertaking. Over the next 15 years this programme as become self-sufficient and is now run locally with MasT still having some input.



IN 2015 MWB contacted the charity expressing an interest in having such a training programme. First questions to be asked were does Mast As a small charity have the capacity to support this? To trial it, it was decided to run a pilot version with 4 students, one of whom was Fabienne Van Eck, the programme manager for MWB in Palestine. It was felt she would offer a

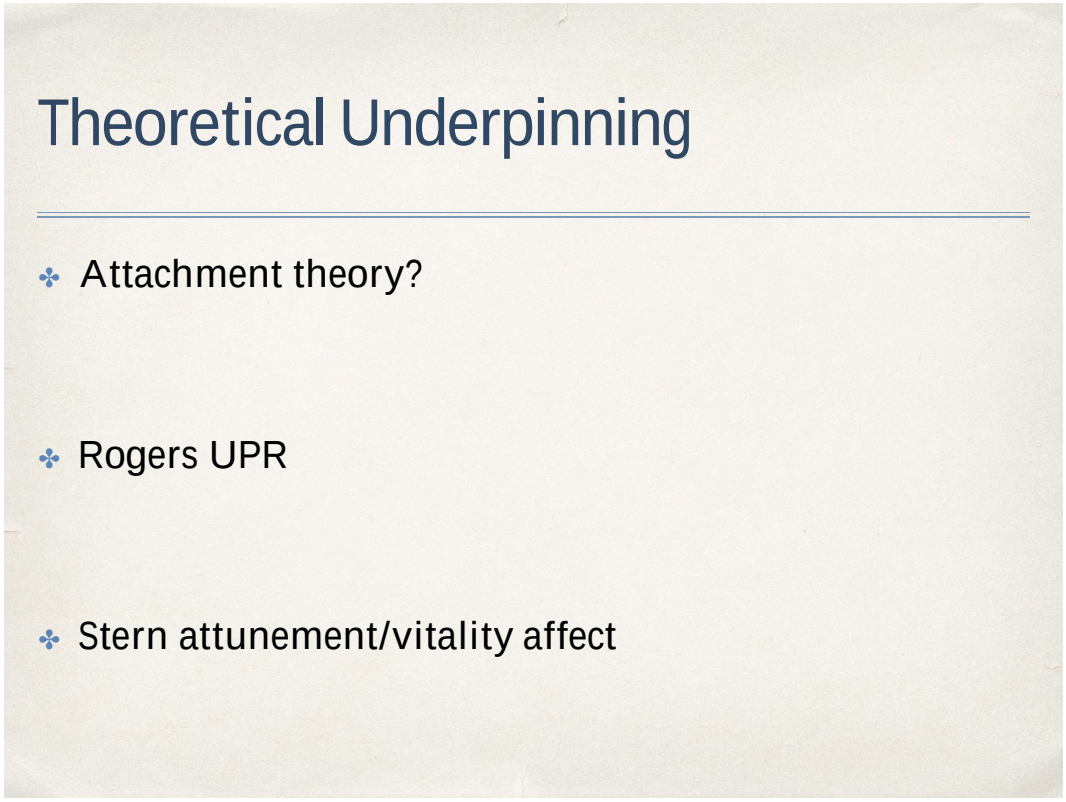
cross-cultural perspective on the programme and also be able to comment on whether the existing programme was fit for purpose. We wanted to know if there were any modifications required to fit the students' needs and the different social and political context. I've worked for MasT in Palestine since 2009 delivering skillsharing programmes and became involved in this latest initiative and partnership.



The plot running of the training raised the following issues:

1. Difficulty for some students in engaging with the directed learning aspects of the course due to unfamiliarity with assignment writing and formal learning.
2. Offering theoretical underpinning that sat well with cultural norms.
3. Life circumstances of some

students being uncertain due to their living situations. For example, if they were living in refugee camps where daily routines were challenging it was difficult to feel rested for work or learning. Some felt they were living in a hopeless situation and therefore struggled to feel motivated in a consistent way. These issues meant decisions had to be taken to ensure the programme was fit for delivery to these students in the future, and that as far as possible, those enrolled were going to be able to complete the training.

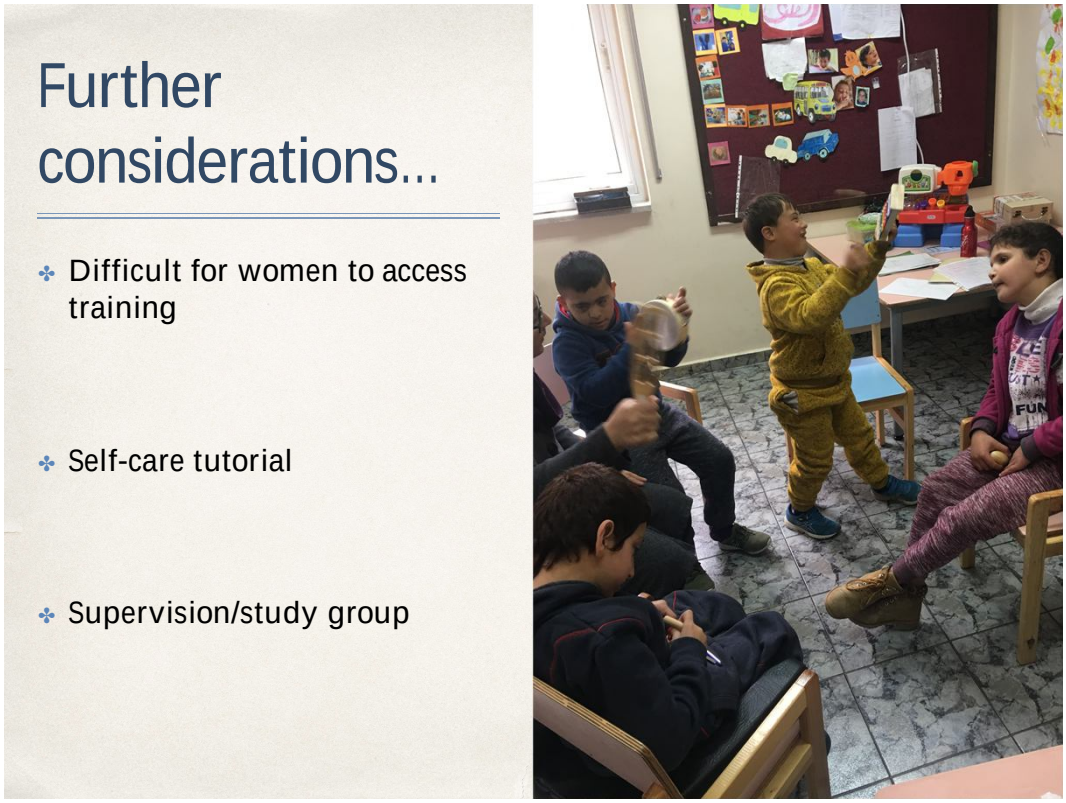


After the pilot decisions were made regarding the theoretical underpinning . In Romania, attachment theory had proved a useful tool for students to look at the relationship-making and interaction patterns of the children with whom they were working. Here in Palestine this didn't seem so useful. Students struggled to identify and understand the different categories of

attachment and apply them usefully. They adopted a critical approach to films of music therapy they viewed, bringing their own cultural understanding of interaction patterns to what they saw in a way that made it difficult to scaffold learning. Students often became focussed on behavioural issues when thinking about musical interactions, sometimes struggling to allow a degree of freedom for musical responses to emerge. We wondered if this was due to them conceptualising the work more as teaching intervention than as therapeutic.

In order to bring a greater degree of clarity to the work we were e3xpecting the students to undertake in the practicum and beyond, it was decided to remove attachment concepts at this stage and

focus on Rogers UPR and Stern's attunement and vitality affect theories. In subsequent evaluations the students all stated how useful they found the UPR in working generally with children and in their personal lives. Stern's ideas were valuable in pair work in the Intensive Study Weekend and in encouraging musical responses while training and subsequently working in the field.



To support students in studying, Fabienne arranged monthly local supervision/study groups for them to attend so they could feel part of a group and not isolated. Students are drawn from cities very far apart, such as Nablus Ramallah, Jerusalem and Bethlehem, so peer support is important. The addition of this extra teaching input has meant we now call

the programme Blended Learning as opposed to simply Distance.
Additionally a portion of one tutorial was devised with MWB support to promote self-care and awareness of the students own needs and feelings. Sometimes the group members students were working with had had challenging experiences that week or day before with military incursions into their homes or villages. The students could empathise with this as well as possibly experiencing it themselves. This had the potential to be challenging for students trying to work therapeutically. The additional tutorial looks at ways of recognising feelings and also how to develop resilience and find ways of recharging batteries /giving themselves a space that would give them support. It was

important for awareness of the impact of stress and anxieties to be brought into conscious working levels for students as they undertook the practicum of the training.

A strong feature of the programme is the Intensive Training Weekend delivered by UK MTs who are generally members of the Advisory Panel of the MasT. I have been one of the pair who delivered this on each occasion that the programme has run to date. We have so far had 3 iterations. It may be that in future when there are more experienced

practitioners in Palestine that this could be run by trainers there. At the moment however students enjoy meeting and working with the MTs having a change to experience working practically while Fabienne their on-the-ground supervisor is also present.

In case you are wondering what these groups might look like here's a clip from one such group. The children have mild LDs or behavioural issues and are working here with a social counsellor. They are using a 'Conductor' activity in which each group member has a chance to be the leader. There will be a chance after all the presenters have spoken to ask

questions about the clip if you wish.
After clip we also notice here in Palestine the groups often us movement based activities, citing that there is little open space for children to play and that they need to move. While some activities therefore such as the one you have just seen take place in a circle, others involve moving around the room, dancing or using traditional Palestinian playgroup games with live music blended into the games.

What's next?

- Continue to develop pool of practitioners
- Considering a mini-conference
- Evaluation - part one completed
- Working together to ensure BLP remains relevant and high quality

We are always thinking about the sustainability long term of this work, and are building a base of practitioners so that peer support can be a part of this. Next year we will be offering a conference to practitioners in Palestine with our local partners. We consider this could be a valuable way of sharing practice and making links between organisations.

In addition part one of an evaluation has been carried our by an Arabic-speaking MT. This consist of interviews of all those who have completed the training. We intend to repeat this process again at the end of the year to track the progress of practitioners. Watch out for a forthcoming paper!

Initial findings show the impact the training has not only in supporting those who complete the programme to develop a therapeutic music practice, but also in ther daily lives. The participants made such comments as: ‘ The most thing I learnt to see the strong points in the children before I see the weak points… to be more patient and tolerant’ Samar.

Adopting a child centred approach was also commonly described as a key thing

that was learnt. This included respecting the children's choices, not forcing children to participate in activities and allowing activities to be child-led: 'How to respect the desire of the children. Like some of the don't want to participate so I don't have to force them to participate, maybe use different activities to let him participate but it's his choice'. Sama

For those who are teachers they spoke about how this approach differed to teaching, describing it as a freer and more child-led approach:

' *I liked in this programme how I can deal with the children who have some needs, like low self-esteem, and I noticed the progress or the development on this child through these activities with music'.* Jihad

Those who had a history of teaching music

or using music for performance describe a shift away from an outcome/performance focus to a therapeutic focus. They described thinking about and using music therapeutically adopting a more child-centred approach.

‘*Like before I was looking at the music, I have to do dance, dabkeh, for example, performance just for performance… Now I am looking at the children, how they will participate in the music. So if was for me like changing… focus on the children.’*

Sama

It was also important for people to be able to recognise that sometimes, what they were doing didn’t work. ‘*You need to be able to use the UPR, but sometimes to tell you the truth nothing is working. I still acknowledge it, I use the 3 who are*

staying to sing for that person to come, to encourage him to come. Sometimes it worked, but sometimes they will not come. ‘ Ahmad

May participants also described positive impacts on their persona lives, using activities and ideas with their own children and nieces and nephews. We collected a very rich data set from this first evaluation and a paper is being written up based on the data.

So to conclude, the BLP in Palestine is flourishing. We have many applicants who are eager to undertake the training. It has been important to ensure the training resonates with local culture and need, and we are currently devising a similar shorter programme for use in Myanmar, where we may see further local differences being

reflected, causing a need to tailor inputs here too. This will give us a chance to reflect on the ‘One Size Does Not Fit All’ approach we have adopted hereto.

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REPORT

Special Feature | Music therapy in dementia and end-of-life care: Mediterranean perspectives

Music therapy in the Occupied Palestinian Territories: An overview and some perspectives on dementia and end-of-life care

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Independent scholar, Occupied Palestinian Territories

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ABSTRACT

This report discusses the practice of music therapy in the Occupied Palestinian Territories (OPT), with a focus on the field of dementia and end-of-life care. It reviews music therapy in general in this part of the world, and also explores the extent to which music therapy is implemented and made available to the general public. Matters relating to access to music therapy trainings are also examined. The impact of culture and lack of trained music therapists in the OPT mean that at present, music therapy work in general is limited. The report concludes by offering glimpses into current initiatives and potential developments for the profession.

KEYWORDS

music therapy,
Occupied Palestinian Territories (OTP),
dementia
end-of-life care

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MUSIC THERAPY IN THE OCCUPIED PALESTINIAN TERRITORIES

This report explores and discusses music therapy in the Occupied Palestinian Territories (OPT). In order to clarify the use of the term OPT, it should be stated that since 1999, this descriptor has been used to describe the following geographical areas: the West Bank, East Jerusalem and Gaza.

Although the focus of this special feature is music therapy in Mediterranean countries in the field of dementia and end-of-life care, the authors found such work was extremely limited if not completely absent in the OPT. This report, therefore, focusses on providing an overview of the profession in the area with some thoughts from local professionals and academics as to the potential for the future development of music therapy generally and in the featured clinical areas.

Music in the OPT

The musical tradition of the OPT is rich and varied. The varying cultural backgrounds and religions present in the country offer a rich underpinning to Palestinian music, enabling it to thrive and develop. From traditional working, wedding and protest songs (Macdonald, 2013; Massad, 2003) as well as performers such as Reem Kelani, music therapist and performer Basel Zayed, and contemporary hip-hop and rap collectives, the Palestinian music scene is eclectic and vibrant.[1] Instruments such as the oud, quanoun, daaf, Arabic drum and ney, together with the use of Arabic modes known as maqams and traditional rhythmic patterns, give Palestinian music a specific colour and shape that is being used creatively by contemporary artists to explore identity and break new ground in this artform.

Music therapy in the OPT

Although at the moment access to music therapy delivered by trained music therapists in the OPT is limited, there remains a positive attitude to the use of music to achieve therapeutic goals. There are few Palestinian music therapists practising in the region, although the exact number is hard to ascertain. According to information gleaned anecdotally (Buran Saada personal communication, 18th February 2019) there are less than five Palestinians who have postgraduate qualifications in music therapy. All of them are located in larger areas of population with none operating in Gaza. When one considers these serve a population of approximately five million people (roughly three million in the West Bank and East Jerusalem and two million in Gaza), it is clear that access to music therapy delivered by Palestinians is severely limited. In addition, there is no generally accepted definition of music therapy which means that the term can be loosely applied to any therapeutic or even educational use of music.

Music therapy training in the OPT

Developing the music therapy profession in this part of the world has many challenges. To some extent, this is due to the lack of university undergraduate or postgraduate level training in music therapy. There is also a difficulty for Palestinian musicians, who may wish to train in this discipline, in accessing any training in this subject area. Although there exist undergraduate and postgraduate courses for social workers, psychologists and other healthcare professions in which seminars on the topic of music therapy are delivered, there is a dearth of any music therapy training in these territories.

[1] See: http://www.reemkelani.com; https://www.baselzayed.com; http://www.iamhiphopmagazine.com/meet-palestinian-artists-breaking-borders-music-boilerroomtv/ (accessed on 24th March 2019)

This means there are considerable barriers to the development of this profession. Indeed, some Palestinians have accessed training in Israeli universities and this is the case for the few Palestinian music therapists currently working in the OPT. However, such courses whether located in Israel, neighbouring countries such as Lebanon where a course does exist, or further afield, can be difficult for Palestinians to attend. There may be issues relating to obtaining visas, as for any potential student wishing to study abroad, as well as the language barrier.

As a result, and also because of the large number of foreign aid agencies operating in the area, several short courses offering music therapy skills take place in the OPT. These can be accessed by Palestinian musicians, teachers and healthcare workers, and provide skills and training in the use of music for therapeutic outcomes.[2] In cases where the organisation is based abroad and not in the OPT, training is often delivered by music therapists who are not native to the region. This in itself brings up questions relating to the relevance of training materials and theoretical approaches, the accuracy of translation of music therapy specific terminology and post-colonial assumptions that are beginning to be explored by music therapists (Comte, 2016; Coombes, 2018).

Music therapy practice in the OPT

Despite these challenges, there do exist pockets of music therapy work being undertaken by Palestinian music therapists. Much of this is group work, partly due to limited resources but also due to the prevailing societal structure. Buran Saada, a Palestinian music therapist who works primarily with children with special needs but also with women with breast cancer and young people who have been imprisoned for offences against the state of Israel, believes that "While there exists a will to use music to support children with special needs, provision for autism and other associated conditions mean any music therapist faces an uphill struggle to develop the work"(personal communication, 18 February, 2019). Furthermore, Souha Shehadeh, a child and adolescent psychiatrist at the Bethlehem Arab Society for Rehabilitation Hospital in Beit Jala, believes that music therapy offers communicative and expressive opportunities for children with autistic spectrum conditions. Her organisation participates in a project organised by a UK based charity, ABCD (2019), who employ UK-trained music therapists for time-limited periods of work in and around the hospital. While this input is relatively short in duration, she believes that "Music therapy offers the children the opportunity to express themselves in music, and gives their parents a sense of hope for their children's future" (personal communication, 15th March 2019).

There are also music therapists from other countries who have undertaken short-term work in the area. A common theme arising in their writings is the importance of identity that can be expressed through music using traditional instruments and rhythms (Behrens, 2012; Coombes, 2011, 2017; Tsolka, 2016). It can be seen, therefore, that there exists a patchwork of music therapy initiatives in the OPT. Local music therapists deliver sessions in a variety of settings, with short or longer-term

[2] See: Al Mada (https://al-mada.ps); Anera (https://www.anera.org); UNRWA (https://www.unrwa.org/where-we-work); Music as Therapy International in conjunction with Musicians Without Borders, (http://www.musicastherapy.org/about/where-we-work); Music Can Help (https://www.music-can-help.de/aktivitaten/musiktherapie/?lang=en); Pro Terra Sancta (https://www.proterrasancta.org/en/meet-me-in-the-sound-through-music-the-music-therapy-course-in-bethlehem/) (accessed on 24th March 2019)

initiatives, while other projects largely funded from outside the OPT provide music therapy and therapeutic music work.

MUSIC THERAPY IN DEMENTIA AND END-OF-LIFE CARE

Bearing in mind the limited provision of music therapy in the region, it is no surprise that access to this intervention in the fields of dementia and end-of-life/palliative care remains virtually non-existent.

In the OPT there are little or no services offering dementia or palliative care. With a relatively young population where average life expectancy is around 75 years, there are few statistics available for dementia, and those that are available include Israel, which makes it difficult to ascertain the extent of the disease in the OPT (Bhalla et al., 2018). Organisational care for dementia and also palliative care is lacking, in part due to a paucity of appropriately medically trained staff, but also due to the prevailing cultural norms. In Arab society, "the desire of appearing strong and to please others at all costs, bearing physical pains, hiding emotions, staying at the head of responsibility, performing duties and playing roles without admitting the need for help or showing signs of weakness" (Abu Seir & Kharroudi, 2017, p.57) means that many people delay seeking treatment and do not wish to receive such palliative care that is available. The same paper discusses the importance given to the family unit in Palestinian culture. The norm would be for "family members […] to take the patient home to be around him to provide comfort and company" (Abu Seir & Kharroudi, 2017, p.57).

Rana Abu Seir, assistant professor in haematology at the University of Al-Quds in Palestine who also specialises in cancer care, acknowledges the lack of access to music therapy for those receiving palliative care (personal communication, 22nd March 2019). She suggests that those of the Muslim faith (98% in the OPT with the remainder largely identifying as Christians) may draw comfort from listening to recordings of the Quran, specifically prayers for remission. These include the concept of hope in the afterlife as a reward of withstanding the pain without complaint. Equally, adherents of other religions, including Christians, may benefit from listening to or singing religious texts from their Holy Books which also contain similar sentiments.

While no literature on the potential of playlists to offer support to those living with dementia and receiving end-of-life care exists specific to the OPT, there is a growing body of such literature in the international community (Leggieri et al., 2019; Murphy et al., 2018; Porter et al., 2017; Warth, Kessler, Hillecke & Bardenheuer, 2015). It is suggested, then that it may be possible to implement the use of playlists as part of a music therapy programme for this client group in the OPT.

LOOKING FORWARD

It is clear that the profession of music therapy faces many challenges in the OPT if it is to develop and be offered to the wider population. The lack of university level music therapy courses in the OPT means that Palestinians who may wish to receive such training struggle to access it. While some level of music therapy training is currently offered by a variety of organisations, without university-level music therapy courses there remain challenges to the development of a system whereby music therapy can be provided by Palestinians to their fellow countrymen.

More positively, the music therapy initiatives that are already being offered, mainly to children and young people, are viewed very favourably by recipients and their families. Comments from staff who had received training from one such initiative offered by Music as Therapy International (MasT) demonstrate their belief in the efficacy of music therapy and their commitment in delivering such work. One school counsellor stated, "The program allows me to help as many students as possible with behavioural and psychological problems and reduces the impact of these challenges on my students". Another stated "I became very close to my students through the music therapy sessions and the confidence and communication between us increased" (Music as Therapy International, 2019). Parents have also commented on their children's music therapy experiences, with one parent stating of her son, "The [music therapy] programme encouraged his own abilities and provided a channel for hidden positive energy. It enhanced his self-confidence and played a role in improving his relationships with his peers in the group" (Evangelical Lutheran Church in Jordan and the Holyland 2018). It could, therefore, be said that developing the music therapy profession and provision in the OPT is a work in progress that, while facing challenges, is ripe for development.

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Ελληνική περίληψη | Greek abstract

Μουσικοθεραπεία στα κατεχόμενα παλαιστινιακά εδάφη: Μια επισκόπηση και ορισμένες προοπτικές για την άνοια και τη φροντίδα στο τέλος της ζωής

Buran Saada | Elizabeth Coombes

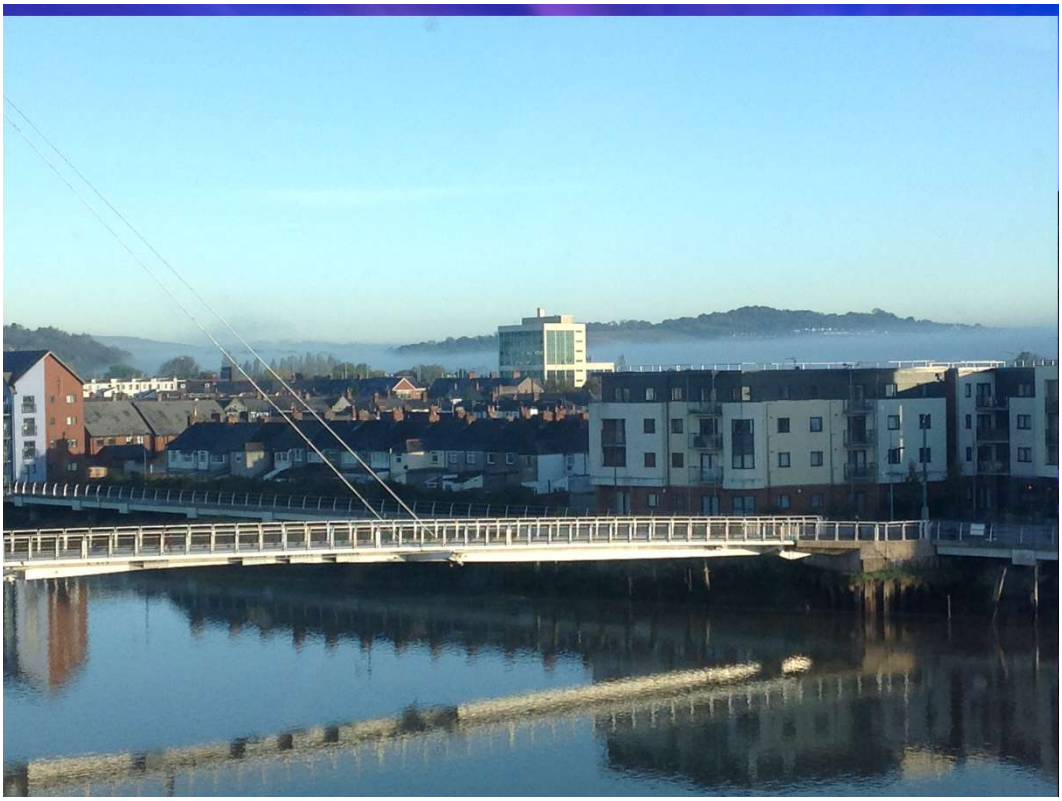
ΠΕΡΙΛΗΨΗ

Αυτή η αναφορά συζητά την πρακτική της μουσικοθεραπείας στα κατεχόμενα παλαιστινιακά εδάφη, με έμφαση στον τομέα της άνοιας και της φροντίδας στο τέλος της ζωής. Εξετάζει γενικά τη μουσικοθεραπεία σε αυτό το μέρος του κόσμου και διερευνά επίσης τον βαθμό στον οποίο η μουσικοθεραπεία υλοποιείται και είναι διαθέσιμη στο ευρύ κοινό. Εξετάζονται επίσης θέματα σχετικά με την πρόσβαση σε εκπαιδευτικά προγράμματα μουσικοθεραπείας. Την παρούσα στιγμή το μουσικοθεραπευτικό έργο είναι γενικά περιορισμένο λόγω των πολιτισμικών συνθηκών αλλά και της έλλειψης εκπαιδευμένων μουσικοθεραπευτών στα κατεχόμενα παλαιστινιακά εδάφη. Η αναφορά καταλήγει προσφέροντας σύντομες ματιές σε τρέχουσες πρωτοβουλίες και πιθανές εξελίξεις για το επάγγελμα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, κατεχόμενα παλαιστινιακά εδάφη, άνοια, φροντίδα στο τέλος της ζωής [end-of-life care]

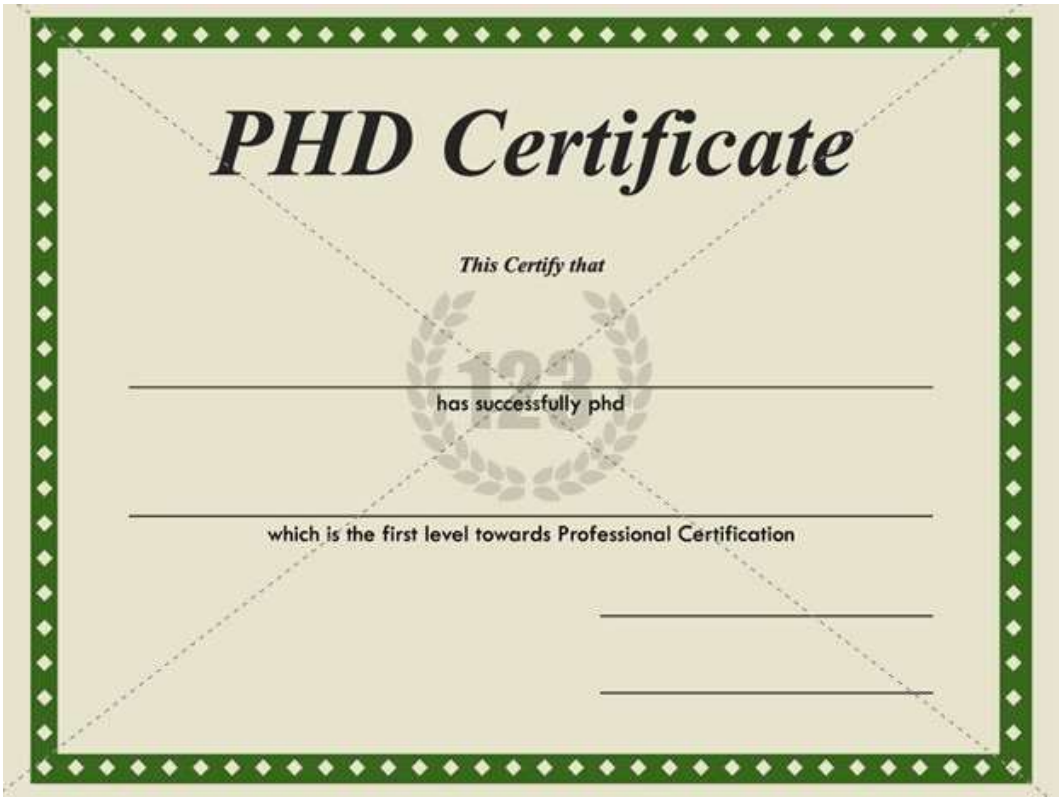
Welcome! Croeso to this PechaKucha. I’m going to tell you about the music therapy study The Singing Unit, describing its origin and potential outcome arising from it.



I’m a PhD student her at USW, and also the Course Leader of the MA Music Therapy course which runs at City Campus in Newport. Behind me you can see the view from my office window.

First of all – what's music therapy? Music therapy is a reflective process wherein the music therapist helps the client to optimise their own health using various facets of the music therapy experience and the relationships formed through them as the imeptus for change.

The music therapy profession is one of the Allied Health Professions and is regulated by the HCPC. The job title ‘music therapist’ is a protected one, and woe betide anyone who uses it without registration. We will get very cross about that!



The Singing Unit forms part of my PhD by portfolio study. Briefly, the pilot consists of 10 sets of parents of babies in the neonatal unit receiving a singing workshop to give them confidence in using their singing voice to interact with their premature babies. Measures will be sued to gauge the workshop's efficacy.

Premature birth can have multiple impacts on the infant. Parental experience of a premature birth can be traumatic. Evidence demonstrates that early intervention focussed on parental competence and bonding improves the parental mental health and child development outcomes.

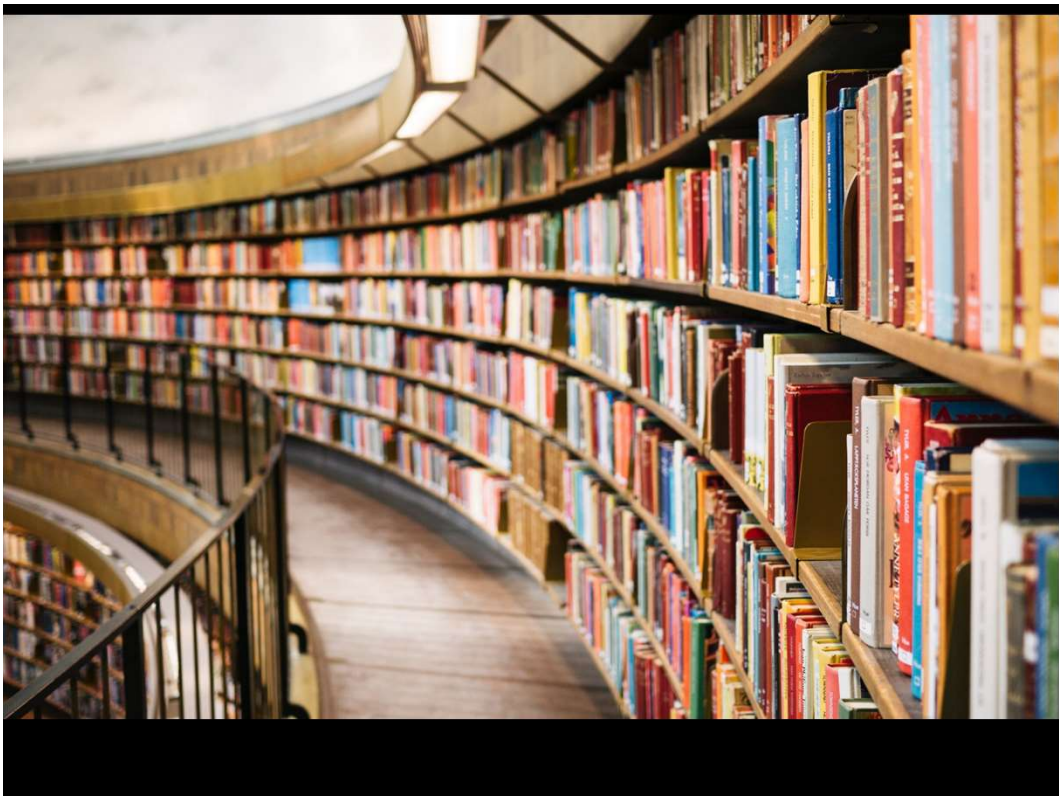
An important part of music therapy theory is the concept of communicative musicality. Evidence shows babies are hardwired to respond positively to and have an appreciation of simple musical structures, melodies and vocal sounds. The parental voice is calming and soothing to babies.

Imagine though that rather than cwtching up to your baby at home, you are faced with your child being in an incubator where communication seems really hard. You're so worried and anxious – what can you do? Well you baby can recognise your voice in preference to all others – why not start here?

International contemporary music therapy practice in neonatal units has produced a number of high quality studies using quantitative and qualitative measures. Outcomes include lessened hospital stays, faster weight gains and improved parental empowerment in caring for baby, and better bonding too.

In Wales, though at the moment we have no such provision. I've therefore devised a pilot study that is take place at Prince Charles Hospital neonatal unit looking at a workshop intervention to supprto parents in singing/humming to their babies.

I was recently at a conference where a presenter remarked ‘Money is the enemy of the dreamer’, . Well this pilot consisting of ne single intervention and some measures is nothing if not low cost.. We will see if in fact it does represent value for money.



In devising the protocol I undertook a literature review. Most studies revolve around clinical music therapy being delivered to infants. Parents play an important part oin many of these interventions. Critical to all methods is the parental voice, and I mean both Mums and Dads.

But how to ensure parents aren't too anxious to sing? The workshop will explain what types of singing will be helpful to baby. Simple examples of singing and humming will be modelled. Parents will be invited to think of giving their baby a vocal cwtch.

We posit then that using simple vocal inrteractions with the baby in the neonatal unit will:

Empower parents

Improve bonding

Reduce stress for parents and baby, enabling parents to feel as though at an abnormal time they can do something normal.,

A mixed methods approach is being used in the study. At point of recruitment parents will complete the full WEMSBWS, HADS and MIBS.

Post workshop a qualitative questionnaire will be completed by parents. Its asks specifically about the workshop and how parents experienced it. Please note that these have been prepared with staff and parental input.

We hope that the workshop will support parents in singing, humming and speaking to their babies. We also hope that even if parents find this idea challenging, it will bring these ideas into their parental world.

At point of discharge in terms of measures, parents will complete WEMWBS, HADS and MIBS again as well as a qualitative questionnaire, focussing on singing with the baby and any challenges that arose.

What do we think we will find out? Possible outcomes are that we hope the workshop will be useful but that the setting might make the singing difficult as the incubators are quite close together. We wonder if more support might be required other than the workshop.

However, we also think that his is a vision for the future. It has the potential to change provision in neonatal care and embed it in the Family Integrated Care Model that is currently used

Thanks for listening.

THE SINGING UNIT
REPORT DECEMBER 2019

Introduction

Despite a significant amount of high-quality research in the practice of music therapy in neonatal hospital environments, the use of music therapy in UK neonatal provision remains sporadic, small scale and poorly documented. For families in Wales, opportunities to access music therapy are extremely limited or non-existent. This has meant that in these settings in Wales, no consensus has yet emerged as to music therapy evidence-based best practice, despite there being music therapy research to support its potential benefits for babies and parents.

Benefits may include shorter hospital stays, faster weight gain and improved parental wellbeing and bonding.

With this in mind, a small mixed methods pilot study involving a cost-effective music-based intervention was delivered by a Health and Care Professions Council (HCPC) registered music therapy for parents of premature infants in the Prince Charles Hospital (PCH) Local Neonatal Unit (LNU) in Merthyr Tydfil. The intervention consisted of a short workshop explaining and demonstrating the benefits of humming/singing with premature babies. Its content is described below.

The focus of the study was the parent-infant relationship; whether the workshop could not only improve parental bonding and wellbeing, but also facilitate empowerment in caring for their babies.

An IRAS application was prepared and submitted, with ethical approval for this being received on 1 July 2019. Confirmation of Capacity and Capability at Cwm Taf Morgannwg University Health Board was received on 12 September 2019, with recruitment into the study commencing on 26 September and ending on 8 November 2019.

Method

Setting
The LNU at Prince Charles Hospital, Merthyr Tydfil provides special and high dependency care for neonates. Most babies over 32 weeks gestation will usually receive their full care at PCH. The unit has 15 cots: one stabilisation / intensive care cot, four high dependency cots and 10 special care cots.

Study design
This was a mixed-methods pilot study using concurrent triangulation. It was also a within-subject repeated measures design.
Three measures were used for the quantitative data collection:

- The Hospital Anxiety and Depression Scale - (HADS). This has two sub-scales, one rating anxiety and the other depression. The higher the score in each the greater the risk of developing a depressive or anxiety disorder. Scores over 8 but less than 11 are

classed as ‘borderline’ by the test, with scores in excess of 11 being considered high risk for developing a depressive or anxiety-related disorder..

- The Mother-to-Infant Bonding Scale - MIBS (Taylor, Atkins, Kumar, Adams and Glover 2005). This is a a short self-evaluating questionnaire. It contains adjectives describing feelings towards the baby and is validated for mothers and fathers. A high score indicates a greater risk for an impaired bonding. The maximum score is 24. A cut-off point of > 2 indicates impaired bonding.
- Full Warwick-Edinburgh Mental Well-Being Scale (Stewart-Brown et al 2009) (WEMWBS). This consists of 14 items rated on a 5-point Likert scale with a maximum score of 70. The higher the score the greater the respondent’s well-being.

Qualitative

Qualitative data was obtained by the completion of two questionnaires, one post-workshop the other at point of discharge. Although one consultant neonatologist, two nurses and one student nurse attended the workshops also, data was only obtained from parents of babies.

Sample

Purposive sampling was used. Families were recruited into the study as they were admitted to the neonatal unit and fitted the inclusion/exclusion criteria:

- the babies should be no more than 36 weeks gestation
- parents should be able to speak and understand English as the workshop and measures/ questionnaires were to be delivered in that language.
- babies were to be medically stable and not receiving Intensive Care.

There are approximately 100 babies per year admitted to the neonatal unit who fit these criteria. For this small pilot the recruitment aim was 10 babies, with the workshop being offered to both parents.

During the recruitment phase, 12 families were approached. One family did not wish to take part. One family agreed to participate, but was unable to attend the workshop and then was discharged before the next workshop could be arranged. This meant that 11 families were recruited in total with 10 progressing to completing the workshop.

The workshop was programmed in as soon as possible after recruitment, with families being asked when they could attend. The programming of the workshop was made flexible for this small pilot. In all, to ensure those recruited received the workshop, 5 workshops were offered. These were attended by the following numbers of parents making 10 families in all:

Workshop	Number of attendees	Comments
29.9.19	4 (only mothers)	Two nurses and a consultant neonatologist also attended
11.10.19	1 (only father as mother at home resting as very stressed)	Two were booked in but one had transport issues and could not attend
1.11.19	2 (both parents)	Two were booked in but one parent was unwell and so other parent opted to wait for next workshop

Workshop	Number of attendees	Comments
8.11.19 a.m.	4 (2 mothers and one mother and father)	One student nurse also attended.
8.11.19 p.m.	2 (mother and father)	Parents were offered morning workshop but mother had not eaten so requested to wait until next workshop.

A post-workshop questionnaire was completed by all, with the second measures being completed at point of discharge as far as possible. It should be noted that the father for the second workshop did not return the discharge measures despite support. This has meant a total of 9 families completing the entire study, with 12 participants in total. Of these, 9 were mothers and 3 fathers.
The workshop consisted of the following elements:

1. A brief outline of the content of the workshop
2. A discussion about the participants' experience with music and musical preferences
3. An acknowledgement of the stressful situation of having a baby prematurely
4. A short relaxation exercise using music listening as a support
5. Information regarding the baby's experience of sound in utero, the development of hearing and other practical matters relating to the optimal way of using a singing/ humming voice with the baby
6. Humming exercises
7. Singing exercises
8. Selection of songs if appropriate and requested
9. Ending of session with short music listening experience

Results

Quantitative

A Wilcoxon signed rank test was used due to the data obtained not being distributed symmetrically around the median. As there were no data for post measurements in 3 cases, namely 5A, 6A and 6B, these cases were omitted from the analyses.

P-values < 0.05 were considered statistically significant (with smaller values providing stronger evidence for significance); p-values ≥0.05 and < 0.1 were considered a trend.

Graph of the raw data:

The graph below shows the values associated with PRE and POST measurements for all four responses.

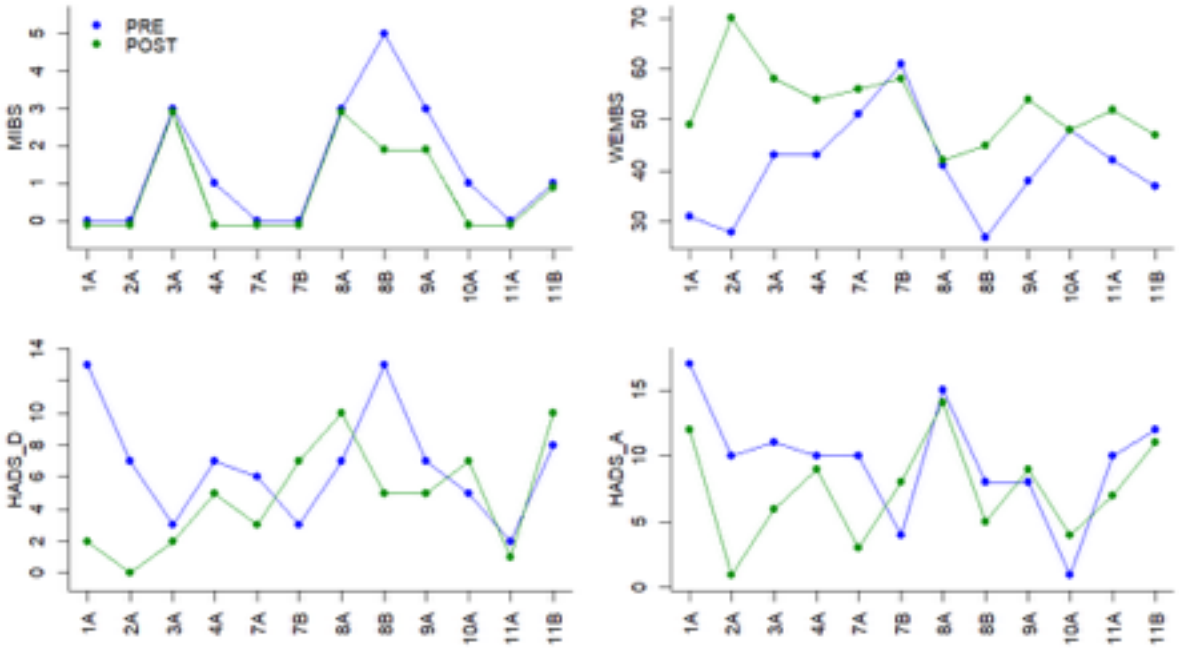


Table 1 below shows the Wilcoxon test results:

Measure: MIBS PRE_POST mean sd median min max 1 PRE 1.42 1.68 1 0 5 2 POST 0.92 1.24 0 0 3 Wilcox.test p-value 0.089	The test indicates **minor evidence in the data for a significant difference** between PRE and POST values (p-value>0.05, but <0.10).
Measure: WEMWBS PRE_POST mean sd median min max 1 PRE 40.83 9.76 41.5 27 61 2 POST 52.75 7.46 53.0 42 70 Wilcox.test p-value 0.007	The test indicates **strong evidence in the data for a significant difference** between PRE and POST values (p-value=0.007).
Measure: HADS_D PRE_POST mean sd median min max 1 PRE 6.75 3.49 7 2 13 2 POST 4.75 3.31 5 0 10 Wilcox.test p-value 0.305	The test indicates **no evidence in the data** for a significant difference between PRE and POST values (p-value>0.10).
Measure: HADS_A PRE_POST mean sd median min max 1 PRE 9.67 4.29 10.0 1 17 2 POST 7.42 3.85 7.5 1 14 Wilcox.test p-value 0.082	The test indicates **minor evidence in the data for a significant difference** between PRE and POST values (p-value>0.05, but <0.10).

The quantitative data then shows that the study indicates a significant difference in increased wellbeing for participants using the full WEMWBS measures. There is minor evidence for improvement in the realm of bonding with the baby for both parents, and also lessened anxiety. No significant difference was found in the depression measures.

Qualitative

The data received from the questionnaires both pre- and post-intervention showed a high degree of positive responses to the workshop. Just over half of the parents felt nervous and apprehensive before the workshop; however, all stated that afterwards they felt very positive about the experience, and that the music listening exercise was very supportive in lessening anxiety. The word 'relaxed' featured often when asked how they felt after the workshop, with all stating they felt 'confident' and 'encouraged' about singing to their babies. Some of those who already had children referenced that they were already doing this at home, but hadn't thought about doing this with their babies.

All stated that the information provided by the music therapist about the best way to sing to support the baby was of the most use. The word 'learning' was mentioned several times. Having an explanation as to why singing is beneficial for parents and babies was highlighted as being of great importance. Several parents stated they would have liked to try the singing with the baby and the support of the music therapist on the ward.

The questionnaire that was completed at or shortly after discharge showed very positive responses to the workshop and idea of singing. Several stated they felt it helped them bond with their baby and noticed that the baby relaxed more quickly when being sung to while being changed or bathed. Parents noticed their baby becoming more alert and looking at their faces. They felt the baby enjoyed being sung to. Many referenced it helping them interact with their baby and feeling happy and relaxed. One father stated 'Seeing the baby's positive response made me feel useful'. Several parents also used the word 'connected' relating to feelings towards the baby.

Difficulties encountered as described by parents were:

- the open space of the ward which made people feel self-conscious.
- the ward being too noisy for singing to be of benefit

All stated they were looking forward to singing at home to their baby.

When asked for any other thoughts, again, some said they would also have liked to have time with the therapist and baby one-to-one to support them. Others referenced enjoying meeting the other parents. One parent stated 'It opened my eyes to a different perspective', while another said ' I found it really good and an amazing way to bond with your baby in the NICU. Fab idea (smiley face)'.

Discussion

As the study proceeded it became clear that that the majority of the work relating to recruitment and obtaining the discharge measures fell to the nurse involved in the study. The Chief Investigator was rarely on site due to work patterns, and the music therapist only attended for the workshop delivery and an initial meeting with the study team. Although working full-time, the shift pattern of the nurse meant that she was only on the

unit for 3 days a week, and, consequently sometimes patients were discharged without the measures being completed. This meant measures were then delivered by the outreach team for completion and returned to the unit. If another nurse had been allocated to the study, this would have made recruitment, planning the workshop dates and obtaining discharge measures more efficient and timely. It may have meant less workshops needed to be programmed as delivering them for individual families was not cost-effective.

There were some issues with the space that was used for the workshop. The parents room was used as it was near the unit, but enclosed so no noise disturbance was evident. This did, however, mean no parents could access the space during the workshop time. Perhaps another space could have been found to ensure parents still had access to the room at the workshop time. It should be noted no parents raised this issue; they were pleased to be near their babies, but unit staff felt this could be a problem.

Although the workshop was highly rated, several parents referenced feeling self-conscious about singing in front of others or wanting one-to-one time with the music therapist. Possibly a short one-to-one session in addition to the workshop with the music therapist on the ward could have further embedded learning and given parents confidence in singing on the ward.

The potential for materials such as prompt-cards and information on the techniques discussed as well as apps with songs or MP3 files may also have been supportive for parents. This would have further embedded learning and possibly increased confidence.

Conclusion and Recommendations

A singing workshop for parents of premature babies in a neonatal unit offers a supportive and useful addition to provision on the unit. It gives parents additional skills in using humming and singing to interact with and soothe their babies. It also involves them in the care of their infants.

The study offers a cost-effective, low intensity intervention that positively impacts wellbeing, bonding and reduces anxiety. It is suitable for a wide range of families in the neonatal unit.

Considerations for future development of this provision would be:

1. A larger study to be undertaken in multiple sites to investigate if these effects can be generalised when delivering the Singing Unit workshop. There could be the potential for this to be an RCT
2. Either involving the music therapist in introducing the study to potential participants to put parents more at ease when engaging with the workshop/study or finding a way to explain the workshop content more fully
3. Consideration in timing recruitment and workshop delivery so that the workshop is not being delivered to single families, rendering it less cost-effective
4. Evaluating whether the HADS is the correct measure to use
5. Creating resources for parents such as information sheets or music apps to support them in singing with their babies

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The Singing Unit – a pilot study investigating the efficacy of a music therapy singing intervention in a local neonatal unit to support parent/infant bonding and reduce parental anxiety.

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Abstract

This mixed-methods pilot study involved the parents of premature infants in a neonatal unit. It explored the impact of parental participation in a singing workshop facilitated by an NICU trained music therapist. This was followed by encouragement to hum or sing with their babies while in the unit. The study showed that after the workshop and hospital stay, a statically significant increase in parental wellbeing occurred. The differences for a reduction in parental anxiety and improved parental bonding were not statistically significant, but may suggest trends for improvement in these areas. This low intensity cost-effective intervention then has demonstrated efficacy in the area of parental wellbeing.

Introduction

Contemporary practice in neonatal units may involve the use of arts-based interventions in addition to medical care ensuring that parents and their babies have access to a range of treatments at this difficult time in their lives (Edwards 2011). Music therapy is one such intervention that is gradually gaining ground in this setting as an evidence-base develops (Bielinink et al., 2016). The music therapist is able to work with parents and their babies using live or recorded music to support them in a variety of ways during their hospital stay.This can include singing with parents and babies, supporting parents sing with their babies, providing soft, relaxing live music, or creating playlists of parent-preferred music to provide opportunities for emotional regulation for the family (Haslbeck 2017).

In XXXX, music therapy provision for families experiencing inpatient stays in neonatal units is extremely limited or non-existent. This has meant that in these settings, no consensus as to music therapy evidence-based best practice in XXXX has been agreed. To add to the evidence base, we proposed a pilot study of a cost-effective intervention to assess whether low-intensity delivery of music therapy could be effective in such settings where music therapy practice is still emerging.

With these factors in mind, a protocol entitled The Singing Unit was devised, and the study undertaken with full ethical approval from the relevant body. The intervention took the form of a one-hour-long singing workshop delivered by a NICU trained Health and Care Professions Council (HCPC)[1] registered music therapist to parents of babies in the neonatal unit at XXXX.

The aims of this study, were to explore whether low-intensity delivery of music therapy could:

- empower parents and increase confidence and competence in being with their babies
- support the reduction of anxiety and depression resulting from the hospitalisation of their babies and improve wellbeing
- enhance bonding between parents and babies

Literature Review

Infants born before the 37th week of gestation are considered pre-term, with prematurity affecting 11% of world births (WHO, 2010). Premature birth can have multiple impacts on the infants' cognitive ability, language acquisition, motor and socio-emotional development (Huhtala *et al.,* 2012). In addition to impacts on the infant, parental experience of a premature birth with admission to hospital can be traumatic. This can cause parental distress, trauma, depression, anxiety and feelings of being out of control. (Obeidat *et al.,* 2009; Yaman and Altay, 2015). There is significant evidence demonstrating that early intervention during hospitalisation focussing on ameliorating parental trauma is effective (Lillas and Turnbull 2009).

There exists a body of writing and research relating to the use of music for premature and medically at-risk babies during hospital stays and its relevance to newborn and premature

[1] In the UK, the title 'music therapist' is a protected title by law. Only those registered with the HCPC can use it.

babies (Edwards, 2011; Gratier and Apter-Danon 2009; Malloch et al. 2012). All writings reference the importance of the voice as means of connecting with the infant, with Malloch et al. using the term 'contingent singing' in their work to describe the specific characteristics required in the singing voice to provide the optimal sounds that will promote a quiet relaxed state in premature babies. These characteristics provide underpinning theory to the increasing numbers of contemporary high quality, music therapy studies in neonatal units that demonstrate a range of positive impacts for parents and babies. The studies use qualitative and quantitative methods (Ettenberger, 2017; Ettenberger, Rojas Cardenas & Odell-Miller, 2016; Loewy et al., 2013; Shoemark et al., 2015; Ullsten et al., 2016;). Ghetti, et al (2019) are in the early stages of an international Randomised Control Trial (RCT) using the idea of music therapists supporting parents to sing during in-patient stays with their premature babies and post-discharge. The above research projects demonstrate clear benefits for patients and families, including:

1. Reduction in length of hospital stay
2. Faster weight gain and increased oxygen saturation
3. Lessened distress during painful procedures
4. Improved parental bonding and empowerment in caring for the infant

Although these studies generally revolve around clinical music therapy being provided by music therapists, parents play an important part in many of the interventions (Ettenberger, 2016, 2017; Loewy 2013). With the lack of evidence based music therapy practice in XXXX and the UK in general, it seemed, therefore, that there was evidence to suggest that a low-intensity music therapy provision could provide a feasible first step for broadening access to this service.

Method

The study design and procedures (IRAS Project ID 266389) were approved by the Health Research Authority (HRA) and Health and Care Research XXX (HCRW) on July 1 2019 with capacity and capability approval being confirmed shortly thereafter by XXXX

Setting

The study and workshops took place in the neonatal unit at XXXX in XXXX. The unit provides special and high dependency care for neonates. Most babies over 32 weeks gestation until term birth will usually receive their full care at XXX. The unit has 15 cots: one stabilisation / intensive care cot, four high dependency cots and 10 special care cots.

Design

This was a mixed-methods pilot study using concurrent triangulation so that both qualitative and quantitative data could be used to more clarify relationships amongst variables. (Creswell et al., 2004). It was also a within-subject related measures design. Figure 1 indicates the structure of the study:

Insert Figure 1 here please.

Qualitative data

This was obtained by the completion of two questionnaires, one post-workshop and the other around the time of discharge from the neonatal unit. The questionnaires comprised of a series of open-ended questions which can be seen in Appendix 1. The questionnaires were designed with input from unit staff and parents who had previously used the neonatal unit. The first questionnaire focused on parental perception of the workshops, and the second enquired as to the usefulness of the intervention as perceived by parents. The

data obtained was analysed using thematic analysis as described by Braun and Clarke (2006).

Quantitative data

Three validated measures were used for the quantitative data collection:

- The Hospital Anxiety and Depression Scale - (HADS) (Zigmond and Snaith 1983). While initially validated for patients only, the scale is also used in occupational health contexts (Stern 214) and has also been used in previous music therapy studies in the NICU (Ettenberger 2016, Ettenberger 2018). The scale has two parts, one rating anxiety and the other depression. The higher the score in each the greater the risk of developing a depressive or anxiety disorder. Scores over 8 but less than 11 are classed as 'borderline' by the test, with scores in excess of 11 being considered high risk for developing a depressive or anxiety-related disorder.
- The Mother-to-Infant Bonding Scale - MIBS (Taylor, et al., 2005). This is a short self-evaluating questionnaire validated for mothers and fathers. A high score indicates a greater risk for an impaired bonding. The maximum score is 24. A cut-off points of > 2 has been suggested by Bienfait et al (2011) as indicating impaired bonding.
- The Full Warwick-Edinburgh Mental Well-Being Scale (Stewart-Brown et al 2009) (WEMWBS). This consists of 14 items rated on a 5-point Likert scale with a maximum score of 70. The higher the score the greater the respondent's well-being.

A comparative statistical analysis was performed for the pre- and post-intervention measurements. As the data obtained was not distributed symmetrically around the median, a Wilcoxon signed rank test was used for analysis. P-values < 0.05 were considered statistically significant. P-values ≥ 0.05 and < 0.1 were considered a trend.

Sample

Convenience sampling was used. Families were recruited into the study as they were admitted to the neonatal unit and fitted the inclusion/exclusion criteria. These were that:

- the babies should be no more than 36 weeks gestation at birth
- parents should be able to speak and understand English as the workshop and measures/ questionnaires were delivered in that language.
- babies were to be medically stable and not receiving Intensive Care.

There are approximately 100 babies per year admitted to the neonatal unit who fit these criteria, so for this small pilot we aimed to recruit 10 babies, offering the workshop to both parents. Eleven families were recruited into the study. Of these, one family was unable to attend the workshop due to travel issues and was then discharged before the next workshop could be arranged. The study then proceeded with 10 families. However, in one case the final measures and second questionnaire were not completed, leaving 9 families who completed the entire study. The participants included 9 mothers and 3 fathers. No data from those who did not complete the study was included in the data analysis.

Table 1 shows the pattern of delivery of the workshops and who attended. The workshop was programmed in as soon as possible after recruitment. Due to the small sample size, the workshops were run when a consensus of time was agreed for the attending families. These times varied from mid-afternoon to early-evening. Participants were only invited to one workshop. Staff members were invited in order that they might gain knowledge in how to support parents in singing with their babies in the neonatal unit. Please note each workshop lasted for one hour and took place in the parents room adjacent to the neonatal unit at XXXX.

Table 1 Workshop attendance pattern.

Workshop	Number of attendees	Comments
1	4 (only mothers)	Two nurses and a neonatologist also attended
2	1 (only father as mother at home resting as very stressed)	Two were booked in but one had transport issues and could not attend
3	2 (both parents)	Two families were booked in, but one parent was unwell and so the other parent opted to wait for next workshop
4	4 (2 mothers and one mother and father)	One student nurse also attended.
5	2 (mother and father)	Parents were offered morning workshop, but mother had not eaten so requested to wait until next workshop.

The workshop was designed and delivered by the music therapist. Approximate timings for each section have been provided. It consisted of the following:

1. A brief outline of the content of the workshop and discussion about the participants' experience with music and musical preferences. The stressful situation of having a baby prematurely was acknowledged. This introduction helped parents feel at ease. (10 minutes)
2. A short relaxation exercise using recorded music as a support. Research suggests this may be supportive to parents with hospitalised children (Wolfe and Woolsey 2003) (5 minutes)
3. Information regarding the baby's experience of sound in utero, the development of hearing and other practical matters relating to the optimal way of using a singing/ humming voice with the baby was then given by the music therapist. This was to ensure parents understood why the workshop was being offered. (10 minutes)
4. Humming and singing exercises using the idea of contingent singing (Malloch et al 2012)
5. Selection of songs if appropriate and requested by parents drawing on Loewy's ideas of Song of Kin (2015) (sections 4 and 5: 30 minutes in total)
6. Ending of workshop with short recorded music listening experience (5 minutes)

Results and data analysis

Qualitative

The data received from the questionnaires both pre and post intervention showed a high degree of positive responses to the workshop. In the first questionnaire, approximately half

of the parents felt nervous and apprehensive before the workshop. All stated that afterwards they felt very positive about the experience, with the word ‘relaxed’ featuring often in their responses. The music listening experience was described as being of importance to support a reduction in their anxiety about singing. All respondents said they felt ‘confident’ and ‘encouraged’ about singing to their babies. Some parents who have older children referenced that they were already doing this at home but had not thought about doing this with their babies in the neonatal unit.

Parents felt that the information provided by the music therapist about singing techniques to support their babies was very useful with one parent stating, ‘It opened my eyes to a different perspective’. The word ‘learning’ was used to describe aspect of the workshop by several parents. Understanding why and how singing can help parents and their babies was also described as being highly relevant. Several parents reported that they would have liked to try singing with their babies while being supported by the music therapist.

The second questionnaire showed very positive responses to parents singing with their babies. Parents stated they felt it helped them bond with their babies and noticed that the babies relaxed more quickly when being sung to while being changed or bathed. Parents wrote that their babies became more alert and were looking at their parents’ faces while they sang to them. They felt this showed the babies were enjoying the experience. Many parents referenced that singing helping them interact with their babies and made them feel happy and relaxed. One father stated, ‘Seeing the baby’s positive response made me feel useful’. Several parents also used the word ‘connected’ relating to feelings towards their babies.

Difficulties encountered as described by parents were the open space of the neonatal unit which made people feel self-conscious and the general noise levels. All stated they were looking forward to singing at home to their baby, an important finding when considering the aims of this study.

Quantitative

The quantitative data was analysed using the non-parametric Wilcoxon test. It indicates a statistically significant increase in wellbeing for parents, using the full WEMWBS measures with a p-value of 0.007. The differences in the MIBS and HADs were not statistically significant, but may be indicative of trends towards improvements, specifically in the reduction in anxiety as measured by the HADs.

Table 2 below shows the Wilcoxon test results:

Table2: Wilcoxon test results

Measure: **MIBS** PRE_POST mean sd median min max 1 PRE 1.42 1.68 1 0 5 2 POST 0.92 1.24 0 0 3 Wilcox.test p-value 0.089 Measure: **WEMWBS** PRE_POST mean sd median min max 1 PRE 40.83 9.76 41.5 27 61 2 POST 52.75 7.46 53.0 42 70 Wilcox.test p-value 0.007 Measure: **HADS_D** PRE_POST mean sd median min max 1 PRE 6.75 3.49 7 2 13 2 POST 4.75 3.31 5 0 10 Wilcox.test p-value 0.305 Measure: **HADS_A** PRE_POST mean sd median min max 1 PRE 9.67 4.29 10.0 1 17 2 POST 7.42 3.85 7.5 1 14 Wilcox.test p-value 0.082	The test indicates **minor evidence in the data for a significant difference** between PRE and POST values (p-value>0.05, but <0.10). The test indicates **strong evidence in the data for a significant difference** between PRE and POST values (p-value=0.007). The test indicates **no evidence in the data** for a significant difference between PRE and POST values (p-value>0.10). The test indicates **minor evidence in the data for a significant difference** between PRE and POST values (p-value>0.05, but <0.10).

Discussion

The results of this pilot study demonstrated that the intervention aims for the efficacy of this cost-effective intervention were largely met. There was an impact on parental wellbeing with trends being observed in the reduction of parental anxiety and improved parental bonding. Parents felt empowered and up-skilled, and the very positive qualitative comments made by parents showed the intervention had a high degree of acceptability to them.

It should be noted that the study protocol was not set to collect any demographic data, nor was any information regarding medical events during the hospital stay and pre-existing mental health issues obtained. A future study might seek to explore these areas and gather additional data. This could offer the opportunity to mine the data from the measures used to determine which aspects of wellbeing were most impacted by the intervention, as this information may be of use in further tailoring the workshop. This would only be possible with a larger study. Further investigation of the trends in reduced anxiety and increased bonding could also then take place.

It was noted that some parents felt they would have benefited from additional one-to-one time with the music therapist. This was not part of the study. In future studies it may be useful to consider whether a referral to a music therapist might be appropriate for some families. There may have been pre-existing mental health issues for some families that might have meant additional support at this difficult time would have been welcomed. The

evidence relating to admission to a neonatal unit due to a premature birth shows that this is a traumatic experience. A music therapist would be able to work therapeutically with the parents, helping them to manage their own emotions at this time.

Parents with older children fed back that although they were singing at home to them, none had thought to do this with their babies while in the neonatal unit. Perhaps this indicates a gap in parental education that is considered a high priority in Family Integrated Care (FiCare) initiatives (http://familyintegratedcare.com/ 2017). FiCare is an extension of the principles of Family Centred Care (FCC) and is used in UK neonatal units to inform the involvement of parents in the care of their infants. There exists the potential for information regarding parental singing to babies to be incorporated into these guidelines.

Although some neonatal unit staff attended workshops, the number of those attending was low due to working shifts. Overall, staff were supportive of the workshop, reassuring parents that their babies were being monitored while they were with the music therapist. Consideration in future studies should be given to ensuring neonatal staff were more fully informed of the study and resulting parental singing interactions with their babies. This may have impacted on parental perception of the neonatal unit being too noisy at times for the singing to be effective, as staff would have been more aware of what parents were trying to achieve.

The study had some limitations. As this was a feasibility study, no control group was used. A future scaled-up study could consider this. No demographic or parental health-related information was collected. This latter would have enabled the provision to have been more effectively tailored in some cases and onward referrals for support made as needed.

Conclusion and Recommendations

The singing unit workshops offered a supportive environment for parents of premature babies while in the neonatal unit. The study offered parents new skills in using humming and singing to interact with and soothe their babies. It also involved them in a direct way in the care of their babies.

This study offered a cost-effective, low intensity intervention that demonstrated a statistically significant increase in parental wellbeing. Trends indicating improvement in bonding and reduction in parental anxiety were also observed. This music therapy intervention is suitable for a wide range of families in the neonatal unit. We are confident that the Singing Unit is acceptable to parents and neonatal unit staff, and can successfully meet the stated aims. We recommend that this intervention is scaled-up and a larger study developed.

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APPENDIX 1

Questionnaire 1

1. How did you feel about taking part in the workshop?
2. How did you feel after the workshop?
3. What was the best thing about the workshop?
4. Was there anything you didn't like about the workshop?
5. Was there anything you think you workshop should have covered?
6. How do you feel about singing with your baby now?

Questionnaire 2

1. Can you tell us about your experience of singing with your baby?
2. Was there anything that made it difficult to sing with your baby?
3. Was there anything that would have made it easier to sing with your baby?
4. Describe your baby's reactions to singing
5. How did singing with your baby make you feel?
6. Is there anything else you would like to say about this study?